DOCUMENT RESUME

ED 291 009 CG 020 541

TITLE	Medicaid: Improvements Needed in Programs to Prevent Abuse. Report to the Secretary of Health and Human Services.
INSTITUTION	General Accounting Office, Washington, D.C. Div. of Human Resources.
REPORT NO	GAO/HRD-87-75
PUB DATE	Sep 87
NOTE	81p.
AVAILABLE FROM	U.S. General Accounting Office, P.O. Box 6015, Gaithersburg, MD 20877 (1-5 copies, free; 6 or more, $2.00 each).
PUB TYPE	Reports - General (140) -- Reports - Research/Technical (143)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	*Crime; *Evaluation Problems; *Federal Programs; Federal State Relationship; *Health Services; Information Seeking; Information Utilization; Medical Services; *State Action
IDENTIFIERS	*Medicaid

ABSTRACT

States are required by the Medicaid law to identify and investigate cases of suspected Medicaid abuse by reviewing recipients' and providers' use of Medicaid services. The General Accounting Office (GAO) conducted an assessment of programs to control recipient abuse in six states and to control provider abuse in four states to determine whether states were effectively identifying Medicaid abuse and to assess the extent of states' actions to apply sanctions against Medicaid abusers. The results revealed that some states were not effectively using their computerized management information systems to identify potential Medicaid abuse, some were reviewing only a small portion of the potentially abusive recipients identified, and most states had applied sanctions against few abusive Medicaid recipients. This document discusses actions needed to assure that state Medicaid agencies operate effective postpayment utilization review programs to identify and prevent abuse of Medicaid services. It includes a series of recommendations designed to: (1) assess the extent of provider and recipient abuse in each state; (2) establish minimum review requirements based on the results of the assessment; and (3) improve the states' use of their management information systems to identify potential abuse. Eight appendices describe methodology used to identify recipient abusers in California and provide comments from the Department of Health and Human Services and six of the states investigated. (NB)

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United States General Accounting Office

GAO

Report to the Secretary of Health and Human Services

September 1987

MEDICAID

Improvements Needed in Programs to Prevent Abuse

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United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-228646

September 1, 1987

The Honorable Otis R. Bowen, M.D.
The Secretary of Health and Human Services

Dear Mr. Secretary:

This report discusses actions needed to assure that state Medicaid agencies operate effective postpayment utilization review programs to identify and prevent abuse of Medicaid services.

This report contains recommendations to you in chapter 3. As you know, 31 U.S.C. 720 requires you to submit a written statement on actions taken on these recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the House and Senate committees having jurisdiction over the Medicaid program, the governors of the states discussed in the report, and other interested parties.

Sincerely yours,

Edward a Klensmore

for

Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

A small percentage of recipients and providers abuse Medicaid services. Abuse occurs when a provider prescribes services that are not needed or are too expensive or when a Medicaid recipient obtains drugs or other services at a frequency or in an amount not medically necessary.

In 1978, and again in 1982, GAO reported inadequacies in states' systems to identify and correct Medicaid abuse. In the current review GAO assessed programs to control recipient abuse in six states (California, Louisiana, Minnesota, Ohio, Texas, and Wisconsin) and provider abuse in four states (California, Illinois, Massachusetts, and Texas) to (1) determine whether states were effectively identifying Medicaid abuse and (2) assess the extent of states' actions to apply sanctions against Medicaid abusers.

Background

The Department of Health and Human Services' (HHS's) Health Care Financing Administration (HCFA) is responsible for developing program policies, setting standards, and ensuring compliance with Medicaid legislation and regulations.

States are required by the Medicaid law to identify and investigate cases of suspected Medicaid abuse by reviewing recipients' and providers' use of Medicaid services. The Medicaid Management Information System was designed in part to facilitate such reviews by (1) putting recipients and providers with similar characteristics into peer groups, (2) comparing recipients' and providers' utilization of selected services to that of their peers, and (3) identifying as potential abusers those individuals who are using services far in excess of others in the peer group. In fiscal year 1985, state and federal costs for design, installation, and operation of the systems were about $430 million.

States can control abusive recipients by restricting them to receiving services from specified providers (known as lock-in), counseling them on proper use of Medicaid services, or requiring their providers to obtain approval from the Medicaid agency before dispensing nonemergency services. States use various techniques to control abusing providers, such as warning letters, manual prepayment review of claims, and terminating or suspending their participation in the Medicaid program.

Results in Brief

Although GAO and others have previously identified weaknesses in states' postpayment utilization review programs and HHS's oversight, HHS has not taken effective action to strengthen management controls.

Some states reviewed were not effectively using their computerized management information systems to identify potential Medicaid abuse, and some were reviewing only a small portion of the potentially abusive recipients identified.

Most states have applied sanctions against few abusive Medicaid recipients. Using different assumptions for the percentage of Medicaid recipients in control programs and annual savings per recipient, GAO estimates that potential cost avoidance in 1985 could have ranged from $54.5 million to over $400 million. (See pp. 25 to 26.)

Principal Findings

Problems in Identifying Potential Abusers

In 1978, GAO reported that states were not effectively using their management information systems to identify abuse.

In response, HCFA established a program to review the systems' effectiveness. The review requirements do not, however, provide for an assessment of the types of abuse states look for, the types of recipients reviewed, and the way the states set norms to define potential abuse. Nor does HCFA provide adequate technical assistance to states having problems using their information systems. Although the agency is required by Medicaid law to provide such assistance, it said it lacks adequate resources to provide technical assistance. That stronger guidance is needed is evident by the variation in the way states use their computer systems and the problems they have. For example:

- California was not focusing its reviews on many types of Medicaid services likely to be abused, such as excessive numbers of prescription drugs and emergency room visits. GAO estimated 4,700 additional abusive recipients received about $4 million in unnecessary services in 1985. (See pp. 28 to 29.)
- Minnesota and Louisiana were focusing their reviews on elderly and institutionalized individuals—groups that are among the least likely to abuse Medicaid services. Using these groups, Minnesota, for example, identified only 16 potential abusers in the fourth quarter of 1985. (See pp. 29 to 32.)
- Illinois was identifying over 59 percent of the state's providers as potential abusers because it was having trouble establishing norms to define potential abuse. (See p. 32.)

Review Requirements Not Adequate

HCFA requires each state to review 0.01 percent of its recipients and 0.5 percent of its noninstitutional providers to identify potential abuse.

According to HHS, an investment in Medicaid computerization is largely wasted if adequate staff and resources are not devoted to reviewing the system's output. The manual states that utilization review programs should be established based on the number of potential abusers identified using reasonable criteria.

GAO found that Minnesota, Wisconsin, and Louisiana were essentially limiting the number of potential abusers reviewed to the minimum needed to meet the federal requirement. For example, in the second quarter of 1985, Wisconsin reviewed 69 of over 21,000 recipients identified as potential abusers. Although Texas, California, and Ohio were reviewing more potential abusers than the federal requirement, the number reviewed was not based on an assessment of the extent of potential abuse in the states.

HCFA established the minimum review requirement not as a measure of program effectiveness, but to ensure at least minimal use of the computerized systems. GAO believes each state's review requirement should be based on the extent of its potential abuse so as to require states to establish more efficient utilization control programs. (See pp. 35 to 40.)

Few Recipients Restricted

Because management information systems are not being used efficiently and effectively for identification and review of potential abusers, little action is taken against most recipients who abuse Medicaid services. A 1983 study by the National Governors' Association found that 20 of 37 states surveyed had fewer than 100 recipients in their lock-in programs, the most common recipient restriction.

Similarly, five of the six states GAO reviewed had less than 0.06 percent of their Medicaid recipients in control programs at the time of GAO's review. The sixth state, Texas, had 1.24 percent of its Medicaid recipients in control programs and reported monthly savings of over $100 for each restricted recipient.

Texas achieved most of its savings without performing detailed reviews of recipients' medical records. Each month, notification letters were sent to the 1,000 recipients identified by computer screens as the highest

users of the Medicaid services screened. Texas has found that 60 percent of the recipients who receive the letters will reduce their utilization of Medicaid services. Recipients who are again identified as potential abusers may be placed in the state's lock-in program. (See ch. 2.)

Recommendations

GAO makes a series of recommendations to the Secretary of HHS designed to (1) assess the extent of provider and recipient abuse in each state, (2) establish minimum review requirements based on the results of the assessment, and (3) improve the states' use of their management information systems to identify potential abuse. (See pp. 43 to 44.)

Agency Comments

HHS said that although it did not necessarily agree that state utilization control practices are deficient, it plans to work cooperatively with the states to improve utilization review programs. While GAO is encouraged by HHS's plans to work with the states, HHS's comments do not address the specific recommendations made in this report or provide details of how or when HHS plans to take actions to improve utilization control programs. Also, GAO disagrees with HHS's suggestion that current state practices may not be deficient and believes that a stronger HHS commitment is needed if utilization control programs are to be strengthened. (See pp. 44 to 46.)

Several states commented that they were opposed to the establishment of uniform criteria for assessing the extent of potential abuse because (1) differences between the states in such things as benefits covered and prepayment controls affect the potential for abuse and (2) the flexibility of the states to try an innovative monitoring approach would be limited. The uniform criteria GAO recommends would be used to develop baseline data for HHS to use in assessing the adequacy of states' efforts to identify and correct abuse. The states would not be limited to use of such criteria in their programs. Differences between state programs in terms of benefits covered and prepayment controls would automatically be factored into the assessments, reducing the amount of potential abuse identified and therefore the number of potential cases that must be reviewed. (See pp. 46 to 54.)

Contents

Executive Summary		2
Chapter 1 Introduction		10
	States Must Prevent Abuse	10
	System to Identify Medicaid Abusers	11
	Objectives, Scope, and Methodology	13
Chapter 2 Controlling Medicaid Abusers Results in Cost Avoidance		16
	Program Results Varied in Six States Visited	16
	Other Studies Show Similar Results	22
	Overall Impact of Recipient Controls	25
	Conclusions	26
Chapter 3 Actions Needed to Improve Postpayment Review Process		27
	Identification Process Not Adequately Assessed by HCFA	27
	Review Requirement Should Be Revised	35
	Internal Control Weaknesses Should Be Corrected	40
	Conclusions	42
	Recommendations	43
	HHS Comments and Our Evaluation	44
	State Comments and Our Evaluation	46
Chapter 4 States Try Different Techniques to Fight Provider Abuse		55
	Provider Education Visits	55
	Education Letters	55
	Manual Prepayment Claims Review	56
	Overpayments Identified Without On-Site Audits	56
	Peer Review	57
Appendixes		
	Appendix I: Methodology Used to Identify Recipients Abusing Medicaid Services in California	58
	Appendix II: Comments From the Department of Health and Human Services	60
	Appendix III: Comments From the State of California	63
	Appendix IV: Comments From the State of Ohio	67
	Appendix V: Comments From the State of Louisiana	71
	Appendix VI: Comments From the State of Wisconsin	73
	Appendix VII: Comments From the State of Minnesota	75
	Appendix VIII: Comments From the Commonwealth of Massachusetts	78

Tables

Table 2.1: Abusive Recipients in Control Programs in the Six States Visited 17
Table 2.2: Cost Avoidance Estimates From Three States for Their Recipient Control Program 18
Table 2.3: Schedule of Estimated Cost Avoidance for California Restriction Program 18
Table 2.4: Comparison of the Average Monthly Utilization of Medicaid Services by Recipients Before and After Being Placed in California's Lock-In Pilot Project 19
Table 2.5: Schedule of Estimated Cost Avoidance for Texas Restriction Program, Fiscal Year 1985 21
Table 2.6: Schedule of Estimated Cost Avoidance for Ohio Lock-In Program 22
Table 2.7: Schedule of Recipients in Lock-In Programs Surveyed by the National Governors' Association 23
Table 3.1: Number of Potential Abusers Identified and Reviewed in Four States, and the Systems Performance Review Requirement 37
Table 3.2: Recipients in the Aid to Families With Dependent Children and Supplemental Security Income-Disabled Class Groups in Wisconsin Identified as Potentially Abusive During Selected Periods 38
Table 3.3: Recipients in the 21-64-Year-Old Non-Long-Term Care Class Group With High Utilization Rates During the Third Quarter of 1985 in Louisiana 39
Table I.1: Projections of Potential Abusers Identified in California Using 5-Percent Sample of Medicaid-Eligible Recipients 58
Table I.2: Projections of Recipients Judged to Be Abusing Medicaid Services 59
Table I.3: Estimated Number of Additional Recipients Abusing Medicaid Services in California and Potential Cost Avoidance From Recipient Control 59

Figure

Figure 2.1: Potential Savings for Recipient Control Programs Using Different Cost Avoidance and Population Variables 26

Abbreviations

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
SURS	Surveillance and Utilization Review System

Introduction

Medicaid is a federally aided, state-administered medical assistance program that served about 21.8 million low-income people in fiscal year 1985. Medicaid became effective on January 1, 1966, under authority of title XIX of the Social Security Act, as amended (42 U.S.C. 1396). Within broad federal limits, states set the scope and reimbursement rates for the medical services offered and make payments directly to providers who render services. Fiscal year 1986 state and federal Medicaid expenditures were estimated at $44.9 billion; the state and federal shares were estimated at $20.2 billion and $24.7 billion, respectively.

The federal government pays from 50 to 78 percent of the Medicaid costs for health services, depending on a state's per capita income. In addition, states are reimbursed for 50 to 90 percent of their administrative costs by the federal government, depending on the functions performed. The Department of Health and Human Services' (HHS's) Health Care Financing Administration (HCFA) is responsible for developing program policies, setting standards, and ensuring compliance with federal Medicaid legislation and regulations.

States Must Prevent Abuse

The Social Security Act requires states to identify and investigate suspected abuse of Medicaid services. Section 1902(a)(30) of the Social Security Act (42 U.S.C. 1396a(a)(30)) requires that states operate utilization control programs to safeguard against unnecessary care and services. States are required to evaluate Medicaid claims after payment (called postpayment utilization review) to identify and correct abuse by Medicaid recipients and providers. Corresponding HHS regulations (42 C.F.R. 456.3 and 456.23) require states to implement a statewide surveillance and utilization control program that, among other things,

- safeguards against unnecessary or inappropriate use of Medicaid services and
- provides general requirements for the control of the utilization of all services provided under the state Medicaid plan.

A provider can abuse Medicaid services by providing services or causing services to be provided in excess of medical necessity or of a type that is more expensive than necessary for the condition being treated. For example, providers can abuse Medicaid by providing unnecessary services, providing inordinate numbers of high-cost services, or "ping ponging" recipients—unnecessarily referring recipients among a group of providers. Recipients can abuse Medicaid by obtaining drugs or other services at a frequency or in an amount not medically necessary. For

example, they may obtain duplicative services, use too many prescription drugs, use the emergency room for nonemergency services, visit providers too often, or use multiple providers unnecessarily (doctor shopping).

System to Identify Medicaid Abusers

The Medicaid Management Information System is a computerized system designed to process claims and give state Medicaid agencies information for internal program management. The Congress initially authorized states to develop and operate systems in 1972 to make Medicaid more efficient, economical, and effective.

In 1980, the Congress, through the Schweiker Amendment (Public Law 96-398), required most[1] states to install Medicaid Management Information Systems and HHS to assure that those systems operated as intended. Since 1972, HHS has been authorized to pay 90 percent of the states' design and installation costs and 75 percent of the operating costs. In fiscal year 1985, state and federal costs for design, installation, and operation of systems in 46 states totaled about $430 million.

The Medicaid Management Information System's Surveillance and Utilization Review Subsystem (SURS) was developed in part to identify providers and recipients most likely to be abusing the Medicaid program. It was designed to provide information to identify and facilitate investigation of potential abuse with minimum manual clerical effort and with maximum flexibility regarding management objectives. SURS consists of a detailed computer history of paid claims, including such data items as provider and recipient identification numbers, dates and types of services, diagnoses, and amounts paid.

SURS establishes, measures, and compares provider and recipient utilization patterns to identify those who show unusual patterns of practice or utilization. The following are the steps in the process used to identify potential abusers.

1. Utilization patterns for each provider/recipient are established using detailed claim data.

[1]The requirement was waived for any state that had a 1976 population of less than 1 million and total Medicaid expenditures (including federal reimbursement) of less than $100 million in fiscal year 1976. Rhode Island, Delaware, Wyoming, and Arizona did not receive funds for Medicaid Management Information Systems in 1985.

2. Like providers/recipients are put into class groups,[2] and average utilization for selected services are computed for each class group.

3. Standard deviation or manually selected values are used as parameters to measure individual provider/recipient utilization patterns for selected services (screening process).

4. If utilization patterns for selected services are within parameters, no further action is required.

5. If utilization patterns for selected services are outside parameters, the providers and recipients involved are considered potential abusers.

SURS staff must then analyze detailed claims data on providers and recipients identified as potential abusers. Additional data may be collected through telephone conversations, letters, and visits with providers to determine if abuse has occurred. When it is determined that abuse has occurred, remedial actions are taken, ranging from education to either terminating or suspending a provider from the Medicaid program or restricting a recipient's choice of provider (known as lock-in).

Monitoring Medicaid Management Information Systems

In 1978, we reported[3] that neither the federal government nor the states reviewed were realizing all potential benefits of the Medicaid Management Information Systems. Specifically, we said that states were often making little use of SURS reports and were experiencing problems in developing screens, setting parameters, and developing class groups. In accordance with the recommendations in our report, the Congress, in 1980, required HHS to (1) develop performance standards and system requirements for states' Medicaid Management Information Systems and (2) conduct annual[4] reviews of the systems.

[2]Providers are grouped according to type of provider (such as dentist, pharmacist, family physician), and recipients can be grouped according to such factors as age, institutional status, and basis for Medicaid eligibility.

[3]Attainable Benefits of the Medicaid Management Information Systems Are Not Being Realized (HRD-78-151, Sept. 26, 1978).

[4]In 1986, the Consolidated Omnibus Budget Reconciliation Act (Public Law 99-272) amended the Social Security Act and changed the requirement that the Systems Performance Review be performed annually. The amendment states that systems shall be reviewed at least every 3 years. Also, reviews may be of the entire system, or of only those standards, system requirements, and other conditions that have demonstrated weaknesses in previous reviews.

HCFA established the Systems Performance Review in 1981. It determines whether a state's Medicaid Management Information System will be reapproved and whether full funding will be available for its operation. A Systems Performance Review standard requires that SURS provide comprehensive health care delivery and utilization data for program management, identify potential defects in the quality of care, and identify suspected instances of provider or recipient fraud or abuse.

In 1982, we reported[5] that the Systems Performance Review included requirements that should assure minimal use of the system by the states, but did not evaluate how effectively states were using SURS to identify and correct abuse, or the extent to which SURS contributed to that activity. This precluded HCFA from obtaining an accurate and complete assessment of system performance.

Our November 1985 report[6] on HHS's second year implementation of the Federal Managers' Financial Integrity Act of 1982 stated that HCFA's internal controls over Medicare and Medicaid payments, including the Systems Performance Review, were not adequate. We found that the monitoring programs did not include essential steps for evaluating the sufficiency of internal controls.

Objectives, Scope, and Methodology

Our objectives were to (1) determine if the Systems Performance Review was adequately ensuring that states were effectively using SURS to identify and review Medicaid abusers and (2) assess the extent of states' utilization control programs and any resultant cost avoidance. We excluded states' efforts to identify Medicaid fraud because a separate review of fraud control units was being done at the request of the Chairman, Subcommittee on Intergovernmental Relations and Human Resources, House Committee on Government Operations. A report on the results of that review was issued in October 1986.[7]

To review HCFA oversight, we visited HCFA headquarters and the HCFA regional offices in Chicago, Dallas, and San Francisco. At the regional offices, we reviewed the results of the Systems Performance Reviews, examined guidelines used to carry out those reviews, and discussed the

[5]Federal Oversight of State Medicaid Management Information Systems Could Be Further Improved (GAO/HRD-82-99, July 30, 1982).

[6]Second Year Implementation of the Financial Integrity Act in HHS (GAO/HRD-86-9, Nov. 8, 1985).

[7]Medicaid: Results of Certified Fraud Control Units (GAO/HRD-87-12FS, Oct. 21, 1986)

reviews with the responsible regional officials. We also reviewed HCFA rules and regulations for utilization control programs.

At HCFA headquarters, we interviewed officials in the Bureau of Program Operations' Division of Medicaid Procedures, Operations Branch, Systems Development Branch, and Operations Initiatives Branch. In the Bureau of Quality Control, we interviewed officials in the Division of Performance Analysis and the Systems Evaluation Branch. We wanted to determine their role in overseeing states' use of SURS data and review the data they collect on states' utilization control programs.

To assess state utilization control programs for recipients, we visited state Medicaid agencies in California, Louisiana, Minnesota, Ohio, Texas, and Wisconsin. The six states were selected because they had large Medicaid programs, accounting for over 26 percent of the total federal and state Medicaid payments in fiscal year 1985, and wide variations in the number of recipients in their utilization control programs.

In the states, we reviewed pertinent rules and regulations on their recipient control programs and, through discussions with state personnel, determined the methodologies used to identify and review potential abusers and determine whether potential abusers identified were subject to state controls.

In each state we obtained information (1) on the types of services the states screen to identify potential abusers, (2) on how the states organized recipients into class groups, (3) on methods used to review the recipients who were identified as potential abusers (also referred to as exceptors), (4) on methods states used to try to modify aberrant utilization patterns, (5) on the results of state programs, and (6) the states had developed on estimated cost avoidance for their recipient control programs. We assessed the reasonableness of the methods used to estimate cost avoidance, but did not verify the accuracy of the estimates.

Because of the limited number of services screened for abuse in California's SURS process, we did an analysis to determine if additional abusers could be identified by screening services that were not being screened by the state. Our objective was to determine if SURS could be used more effectively to evaluate states' abuse problems and identify additional abusers. The analysis was based on a statistically valid sample of 5 percent of the individuals eligible for California's Medicaid program and the paid claims history file for each sampled recipient. (See app. I for additional details on our methodology.)

To obtain information on states' provider control programs, we visited state Medicaid agencies in California, Texas, Massachusetts, and Illinois. The four states accounted for about 23 percent of total fiscal year 1985 Medicaid payments. In each state we reviewed rules and regulations pertaining to their provider utilization programs and, through discussions with program officials, determined their methodologies for identifying, reviewing, and applying sanctions against abusive providers. Where available, we obtained information on any identified cost avoidance data from their programs, but did not verify the accuracy of the estimates.

We also reviewed our prior reports on Medicaid Management Information Systems and reports on states' Medicaid recipient control programs prepared by the HHS Inspector General, the National Governors' Association's Center for Policy Research, and Pracon, Inc.[8]

We did not do a reliability assessment of the Medicaid Management Information Systems' claims data used in our analyses because HCFA had completed Systems Performance Reviews in those states where analyses were made and found that the claims data were being accurately processed.

Except as noted above, we performed the review in accordance with generally accepted government auditing standards between April 1985 and June 1986. A draft of this report was reviewed by HHS and the states included in our review. Their comments are incorporated where appropriate.

[8]Pracon, Inc., conducted its study under contract to Hoffman-La Rouche, Inc.

Controlling Medicaid Abusers Results in Cost Avoidance

States generally control abusive recipients by (1) restricting them to receiving services from specified providers (lock-in), (2) notifying them on proper use of Medicaid services (notification or monitor letters), or (3) requiring providers to obtain approval from the Medicaid agency before they provide specified nonemergency services (prior authorization) to recipients under sanctions. Because the sanctions are established by the states, the types of sanctions available vary from state to state.

By controlling Medicaid abuse, states can avoid payments for unnecessary Medicaid services. Of the six states we visited, three had developed data showing that they were avoiding payment for millions of dollars worth of medically unnecessary Medicaid services through recipient control programs. The HHS Inspector General and the National Governors' Association have also reported cost avoidance resulting from actions to control abusive recipients. There are significant variances, however, in the size and types of states' recipient control programs and the cost avoidance reported. Using a range of assumptions for the percentage of Medicaid recipients in control programs of 0.5 to 1.5 percent and a range of annual cost avoidance per recipient of $500 to $1,250, potential cost avoidance in 1985 could have ranged from $54.5 million to over $400 million.

Program Results Varied in Six States Visited

Texas had 1.24 percent of the state's Medicaid population in its recipient control program compared to 0.06 percent or less in the other five states we visited (see table 2.1). Not surprisingly, Texas also estimated the largest cost avoidance—over $11 million—in fiscal year 1985, although California ($231) and Ohio ($216) estimated larger monthly savings per controlled recipient than Texas ($106) (see table 2.2).

Table 2.1: Abusive Recipients in Control Programs in the Six States Visited[a]

State/type of control	Recipients in control programs	
	Number	Percent of Medicaid population
California:		
Prior authorization:		
Drugs	255	
Office visits	282	
Drugs and office visits	339	
Lock-in	55	
Letter	1,155	
Total	**2,086**	**.06**
Texas:		
Lock-in	640	
Letter	4,527	
Post lock-in monitoring[b]	4,278	
Total	**9,445**	**1.24**
Ohio lock-in	**635[c]**	**.06**
Louisiana lock-in	**32**	**.01**
Wisconsin lock-in	**106**	**.02**
Minnesota lock-in	**161**	**.05**

[a]The numbers of recipients in control programs were as of December 1986 in California; August 31, 1985, in Texas; April 1, 1985, in Ohio; January 30, 1986, in Louisiana; December 31, 1985, in Wisconsin; and September 30, 1985, in Minnesota.

[b]Texas monitors recipients' use of services after they are released from the lock-in program.

[c]In commenting on a draft of this report, Ohio said that as of June 1, 1987, the lock-in program had 1,050 recipients.

Table 2.2: Cost Avoidance Estimates From Three States for Their Recipient Control Program[a]

State	Period analyzed	Cost avoidance	
		Total	Per recipient per month
California	July-Sept. 1983	$2,336,460	$231
	Feb.-Apr. 1984	2,850,900	
Texas	Fiscal year 1985	11,265,579	106
Ohio	Mar. 1984-June 1985	2,163,158	216

[a]Wisconsin, Minnesota, and Louisiana had not estimated cost avoidance, although Wisconsin had done a limited analysis of seven recipients that showed an average cost avoidance of $615 per enrollee over a 9-month period.

Of the states visited, only California used a prior authorization program, requiring physicians to obtain approval from the Medicaid agency before dispensing drugs, providing an office visit, or both to a recipient under sanctions. California reported average cost avoidance ranging from $160 to $400 per recipient per month for its various prior authorization programs during the two periods for which the state had developed cost avoidance estimates. (See table 2.3.)

Table 2.3: Schedule of Estimated Cost Avoidance for California Restriction Program[a]

Type of sanction	Months sanctioned	Estimated	
		Savings per month	Total savings
Prior authorization for:			
Drugs			
(July-Sept. 1983)	4,996	$160	$799,360
(Feb.-Apr. 1984)	3,425	200	685,000
Office visits			
(July-Sept. 1983)	3,510	300	1,053,000
(Feb.-Apr. 1984)	4,833	300	1,449,900
Combination of drugs and office visits			
(July-Sept. 1983)	1,145	400	458,000
(Feb.-Apr. 1984)	1,500	300	450,000
Lock-in[b]			
(Feb.-Apr. 1984)	88	200	17,600
Letters			
(July-Sept. 1983)	435	60	26,100
(Feb.-Apr. 1984)	2,484	100	248,400
Total	**22,416**	**$231**	**$5,187,360**

[a]The state's estimates were based on utilization data for samples of recipients subject to controls during the quarters analyzed. The cost avoidance figures were based on a comparison of services utilized during the quarter before and the quarter after controls were imposed.

[b]Comparable lock-in program data were not available for the quarter July-Sept. 1983.

California also developed detailed cost avoidance data under its lock-in pilot project[1] operated in the Los Angeles and San Francisco areas. Table 2.4 shows average monthly utilization of selected services by the 47 recipients in the program before their being placed in the pilot project and their average utilization during the control period. Before being placed in the program, the recipients were seeing at least three providers, while during the program, they were required to obtain all care through one primary care provider. The average monthly cost avoidance was $217 per recipient in the Los Angeles area and $169 in the San Francisco area.

Table 2.4: Comparison of the Average Monthly Utilization of Medicaid Services by Recipients Before and After Being Placed in California's Lock-In Pilot Project

	Average monthly utilization	
Service	Before lock-in	After lock-in
Office visits	14.65	1.55
Emergency room visits	0.87	0.11
Controlled substance prescriptions	18.30	1.60

Both Texas and California were using letters informing recipients that their use of Medicaid services was above normal and would be monitored. Texas made the most extensive use of this option, sending letters to 1,000 recipients identified as the highest utilizers of the services screened each month. The letters are sent automatically without a manual review of the recipients' utilization history. Texas has targeted its notification letters to the recipients most likely to be abusive by excluding recipients aged 60 years and older or under 12 years and terminally ill and institutionalized recipients. Texas Medicaid officials said that they have found that few overutilizers exist in these groups.

In commenting on a draft of this report, California said that it is not advisable to send letters to recipients without first reviewing their records to determine if the use was justified. California said that the most carefully written documents are often misunderstood and that it would not want to threaten sanctions due to high utilization for a recipient with a prolonged or severe illness. Ohio, in its comments, however,

[1]The lock-in pilot project began in September 1982, and the last recipients were placed in the program in August 1985. The project's purpose was to determine whether restricting abusive recipients to specific providers would reduce Medicaid expenditures, provide better medical case management, and cause a change in the way abusive Medicaid recipients sought medical care. The state found the program was effective in reducing the number of office visits and prescriptions for abusive recipients as well as reducing costs to the program while ensuring access to quality medical care when needed. California is now implementing the program, to be referred to as the Primary Care Provider Program, statewide.

said that it agreed with Texas' assumption of targeting its notification letters.

The notification letter informs the recipients that their utilization is above normal and provides a publication explaining how to make the best use of Medicaid services. It suggests that recipients obtain most of their care through one physician and pharmacy. The letter states that the recipient's utilization will continue to be monitored, and if inappropriate utilization is again identified, the recipient will be subject to counseling or restriction to one physician and pharmacy. The letter also gives the recipient the opportunity to provide information justifying his or her high utilization of services.

Texas has found that 60 percent of the recipients receiving the notification letter have changed their utilization patterns so as not to be considered potential abusers when their cases are re-reviewed. This has allowed the state to affect utilization patterns without going through the manual review of detailed SURS reports.

Recipients who receive notification letters and are later identified again as potential abusers become subject to the state's lock-in program. Their cases are manually reviewed and if abuse is identified, the recipient is restricted to one provider and/or one pharmacy. Recipients are released from the lock-in program after they demonstrate normal utilization of Medicaid services. Texas also monitors recipients' use of Medicaid services after the recipient is released from the lock-in program. Texas officials believe it is important that they follow up on the initial notification letter and take further action if warranted. Otherwise they believe recipients would learn to disregard the letter and continue abusing Medicaid services.

Texas limits the number of letters sent to 1,000 a month based on staff available to follow up on the estimated 40 percent of the recipients who continue to be identified as potential abusers of Medicaid services. In 1985, Texas had adequate staffing to manually review 400 cases a month to make restriction determinations. As shown on table 2.5, Texas estimated that warning letters resulted in cost avoidance of $120 per recipient per month during fiscal year 1985, accounting for over two-thirds of the state's reported cost avoidance.

Table 2.5: Schedule of Estimated Cost Avoidance for Texas Restriction Program, Fiscal Year 1985[a]

Sanction	Number of months recipients under sanction	Savings per month	Total savings
Letter	63,106	$120	$7,572,720
Lock-in	7,839	133	1,042,587
Post lock-in monitoring	34,872	76	2,650,272
Total	**105,817**	**$106[b]**	**$11,265,579**

[a]Texas has integrated its cost avoidance program into its SURS, identifying the Medicaid records of recipients enrolled in the program for use in cost reporting. The recipients' average cost of services per month before and after corrective actions were compared. The average cost avoided per recipient per month was calculated and multiplied by the number of recipients sanctioned per month to obtain cost avoidance data.

[b]GAO-computed figure.

California reported less cost avoidance for its warning letters (an average of $80 per recipient per month in two quarters analyzed), and it made less use of the letters. As of December 1, 1986, California had 1,155 recipients in its monitor letter program.

The other four states reviewed (Ohio, Wisconsin, Louisiana, and Minnesota) operated lock-in programs, but generally did not use other sanctions for recipient abuse.[2] As shown in table 2.1, the four states had 0.06 percent or less of their Medicaid recipients enrolled in a lock-in program. Of the four states, only Ohio had estimated cost avoidance. As shown by table 2.6, Ohio estimated cost avoidance of over $2 million between January 1984 and June 1985, an average of about $216 per recipient per month.

[2]In commenting on a draft of this report, Ohio said that it refers some recipient abuse cases to local welfare offices and to county prosecutors.

Table 2.6: Schedule of Estimated Cost Avoidance for Ohio Lock-In Program[a]

Period	Cost avoidance	
	Total	Per recipient month[b]
Jan.-Mar. 1984	$117,094	$250
Apr.-June 1984	241,756	258
July-Sept. 1984	667,592	282
Oct.-Dec. 1984	321,212	127
Jan.-Mar. 1985	405,535	201
Apr.-June 1985	409,969	176
Total	**$2,163,158**	**$216**

[a]Cost avoidance was estimated by comparing the cost of medical services for recipients in the program prior to their being enrolled to the average cost for a Medicaid recipient. The system assumes medical costs for restricted recipients will decrease to the cost of the average Ohio Medicaid recipient. In commenting on a draft of this report, Ohio said that its new Management Information System is now operating and that the state will explore the possibility of tracking savings per recipient.

[b]GAO-computed values.

Other Studies Show Similar Results

The HHS Inspector General and the National Governors' Association's Center for Policy Research have also issued reports showing that recipient control programs are cost effective, but not widely used.

Inspector General's Report

In 1983, the HHS Inspector General issued a report[3] on abuse and diversion of Medicaid-funded prescription drugs. The report pointed out that restriction programs prevent substantial unnecessary costs, but savings could be increased through improvement and expansion. The report estimated that the 35 states with programs controlling the most serious drug abusers may save as much as $49 million annually. It was estimated that an additional $94 million could be saved annually if control programs were expanded to all states and if their effectiveness were improved.

The Inspector General's study found wide variations in the percentages of recipients in control programs among the states studied. According to the Inspector General, these differences could not be explained solely by geographic variations in the extent of abuse or the length of time that the programs had been operating. The report cited the apparent key factor in the differences as the states' relative effectiveness in identifying and reviewing recipients with high utilization patterns. (See ch. 3.)

[3]Prescription Drug Abuse and Diversion in the Medicaid Program, Oct. 1983.

The Inspector General cited two studies showing that restriction programs appear to be cost effective. A study on Minnesota estimated annual administrative costs per recipient of $1,782 compared to annual savings in benefit payments of $2,789, a net annual savings of $1,007 per recipient. California estimated annual direct cost of operating its restriction program of about $500,000, with about 10 times that amount in annual savings.

The report also stated that many of its findings and recommendations may apply to Medicaid services as a whole, since the problems of prescription drug diversion and abuse occur as part of the larger problem of fraud and abuse.

National Governors' Report

In 1983, the National Governors' Association's Center for Policy Research issued a study[4] of state Medicaid recipient control programs based on information from 37 states responding to its survey. The study reported on the different mechanisms designed by state Medicaid administrators to reduce inappropriate utilization of Medicaid services, including patient counseling and education programs, prior authorization programs, and "lock-in" programs.

The National Governors' Association reported that in the 25 states providing data, gross annual savings averaged about $1,000 per recipient in their lock-in programs. It also showed, however, that the percentage of the statewide Medicaid populations in recipient lock-in programs varied from 0.003 percent in three states (Arkansas, Texas, and West Virginia) to 1.73 percent in Illinois. Further, most states at that time had fewer than 100 recipients in their lock-in programs. Table 2.7 shows the approximate distribution of the number of restricted recipients among the states surveyed by the association.

Table 2.7: Schedule of Recipients in Lock-in Programs Surveyed by the National Governors' Association

Number of recipients restricted	Number of states
1 - 100	20
101 - 200	8
201 - 500	4
501 - 1,000	2
+1,000	3
	37

[4]Reducing Excessive Utilization of Medicaid Services: Recipient Lock-in Programs, June 1983.

The study showed that about 70 percent of all lock-in recipients in states they surveyed were in Illinois. The report stated, however, that the heavy concentration did not appear to be due to Illinois' having more restrictive criteria than the others. The report states it more likely reflected Illinois' decision to allocate the necessary administrative resources to review and, when appropriate, restrict individuals exceeding its utilization criteria.

The National Governors' Association said that 19 of the 20 states reporting administrative costs to operate their lock-in programs more than recouped those costs in the form of program savings. According to the association, the average benefit-to-loss ratio for the 20 states, weighted by program size, was $12.79 to $1.00. Only Arkansas, which had only seven recipients in its lock-in program, reported that administrative costs exceeded program savings. The association also noted that as long as utilization review is a federally mandated function, a large portion of lock-in program expenditures represent fixed costs.

The National Governors' Association also reported on other programs to control Medicaid abuse. Four states were operating prior authorization programs, with enrollments in the three states providing data ranging from 38 to 1,336 recipients. Michigan, which had 1,336 recipients in its program, had analyzed 468 recipients' utilization before and after they were placed in the prior authorization program. They found that the recipients experienced decreases of 94 percent in the number of physician encounters and 95 percent in the number of prescriptions. The decrease in services resulted in an average annual decrease in expenditures of $4,528 per recipient and a total cost avoidance of $1,119,116 over the projected base period utilization.

According to the National Governors' Association, adequate data were not available on the administrative costs to operate the prior authorization programs. The association said, however, that the heavier reliance on county personnel to approve service requests might cause the administrative costs to be somewhat higher than those of a lock-in program, reducing the difference in net savings.

The National Governors' Association also reported that 13 states and the District of Columbia were operating patient education programs. In the 12 jurisdictions providing data, the number of recipients in the programs ranged from 0 to 1,370. No cost avoidance estimates or administrative costs were reported for education programs.

Overall Impact of Recipient Controls

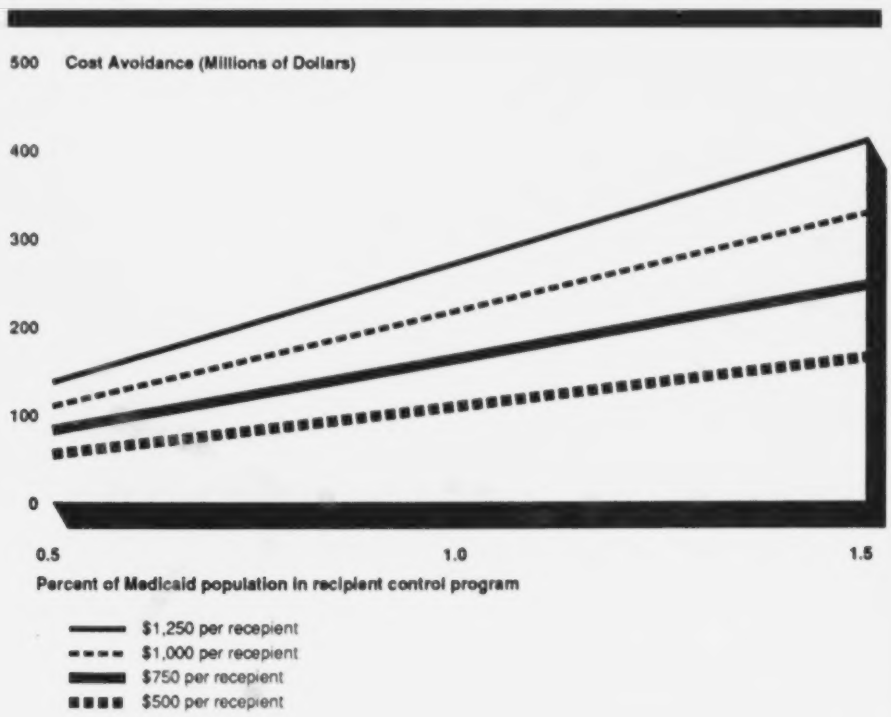
As shown above, in the six states visited and in researching other studies on recipient control programs, we found wide variations in both the percentage of states' Medicaid populations in recipient control programs and the cost avoidance estimates developed for the programs.

To provide some perspective on the potential for cost avoidance from recipient control programs nationwide, we developed several scenarios using different variables for both (1) the nationwide percentage of the Medicaid population[5] in states' control programs and (2) the annual cost avoidance per recipient controlled, which we set at $500, $750, $1,000, and $1,250. Our first scenario used a nationwide percentage of Medicaid population in states' control programs of 0.04 percent, the average level achieved by five of the six states we visited. Under this scenario, potential cost avoidance nationwide ranged from about $4.4 million, assuming a $500 per recipient annual savings, to about $11 million, assuming a $1,250 per recipient annual savings.

We then developed scenarios using assumptions for the percentage of the Medicaid population in control programs of 0.5 percent, 1.0 percent, and 1.5 percent, a range which moves up to and beyond the 1.24-percent level in Texas' recipient control program. As shown in figure 2.1, using the minimum variables, 0.5 percent of the Medicaid population in control programs, and annual cost avoidance of $500 per recipient, the total potential annual cost avoidance increases to $54.5 million. The total increases to over $400 million using the highest assumptions for the two variables.

[5]Our percentage of the Medicaid population in control programs was based on the approximately 21.8 million Medicaid recipients in fiscal year 1985.

Figure 2.1: Potential Savings for Recipient Control Programs Using Different Cost Avoidance and Population Variables



Conclusions

Controlling Medicaid abusers can avoid payment for millions of dollars in unnecessary Medicaid services. Although only limited data were available on the cost of operating restriction programs, both the National Governors' Association and HHS's Inspector General concluded that they were cost effective and should be expanded. However, most states have few of their Medicaid recipients in control programs.

States should use SURS more effectively and efficiently to identify and correct Medicaid abuse. Chapter 3 discusses the inadequacies in HCFA's oversight of states' use of SURS to support their control programs, the resulting problems states were having in using SURS programs, and recommendations to improve the postpayment review process.

Actions Needed to Improve Postpayment Review Process

In 1978 and 1982 we made a series of recommendations to HHS to eliminate weaknesses in states' utilization control efforts that were hampering the effectiveness of SURS in identifying and correcting Medicaid abuse. HHS has not taken adequate action to strengthen program controls in response to our recommendations. As a result, some states we visited were experiencing problems using SURS to identify potential abusers or were making only minimal use of data generated by SURS, similar to the problems identified in our 1978 and 1982 reports.

Our 1985 report on HHS's second year implementation of the Federal Managers' Financial Integrity Act recommended that HHS include internal control weaknesses identified by GAO, the Inspector General, and other reports under the act's reporting requirements. HHS did not concur, and because the weaknesses in utilization control programs were not included in HHS's reporting and tracking system, there is less assurance that they are being monitored and corrected.

Identification Process Not Adequately Assessed by HCFA

In 1978, we reported that states were having problems in screening appropriate services and class groups to identify abuse and in setting exception parameters to control the number of potential abusers identified. Although HCFA later developed the Systems Performance Review, it does not adequately evaluate the states' effectiveness in using SURS to identify potential abusers. Also, HCFA does not routinely provide technical assistance to states or disseminate information on best practices. As a result, states were still having the same types of problems described in our 1978 report.

Review Requirements Not Adequate

HCFA's Systems Performance Reviews do not adequately assess the effectiveness of states' identification processes. While the review's stated purpose is to improve the effectiveness and efficiency of the Medicaid program, it is being used primarily with regard to SURS to determine whether state systems are in place and being used. Little emphasis is placed on the effectiveness of SURS in identifying potential abusers. There are no specific requirements to evaluate the effectiveness of a state's screens, class groups, or parameters or to develop criteria with which to make these evaluations.

The Systems Performance Review requires that SURS's capabilities be utilized to aid in program management and system improvement.[1] Specifically, states should (1) adjust SURS exception criteria to meet program needs so as to facilitate program evaluation and planning and (2) establish and use SURS-related feedback mechanisms for improving system performance. HCFA reviewers are instructed to use state documentation to determine if states are meeting these requirements.

The review does not require states to develop overall information on their potential abuse problems, which could be used as criteria to evaluate the effectiveness of the screens, class groups, and parameters used by the state. Also, HCFA reviewers are not instructed to collect or use program results, such as the number of potential abusers identified by SURS, the number of potential abusers reviewed by the state, or the number of potential abusers under sanctions, either (1) as a measure of states' progress in addressing their Medicaid abuse problems or (2) as indicators of problems states may be having in using SURS.

Some Types of Abuse Not Detected

SURS should be programmed to monitor services that are the most likely to be abused and to use screens, referred to as report items, that best indicate abuse of these services. In 1978, we reported that the states we reviewed were using differing numbers and types of report items because they were uncertain as to what were the most appropriate report items to use to identify the various types of abuse.

Our current review showed that states continue to have problems in selecting appropriate screens. For example, between 1977 and 1981, California reviewed cases only for abuse of drugs, primarily codeine compounds. According to California, one of the reasons its initial efforts were in the area of abusable drugs was concern about the health status of recipients. Although California added a screen to detect office visit abuse in 1981, it was not adjusting its report items to screen for other types of abuse, such as excessive visits to the emergency room or excessive use of other types of prescription drugs. The chief of California's Bureau of Utilization Review agreed that the limitations on the types of services screened and the number of class groups used (see p. 31) had resulted in the state's underutilizing SURS capabilities.

[1]The review also requires that a specific percentage of SURS output be used, that required reports be produced, and that the reports be timely.

To determine if additional abusers could be identified in California, we analyzed a 5-percent sample of individuals eligible for Medicaid in the quarter April through June 1984 using four additional screens, including the number of prescriptions, provider visits, emergency room visits, and different providers.[2] We estimate that about 4,700 more recipients should have been subject to state sanctions. About $4 million in annual Medicaid payments could have been avoided, according to our estimates.[3]

According to California, it has instituted many changes in the recipient screening program since late 1984 to better identify potential abuse. These changes include establishing screens for (1) drug prescriptions that have a high abuse potential and (2) the number of office, outpatient, or emergency room visits for which the diagnosis was a "common" one instead of all provider or emergency room visits.

California also said that it now uses screens in combination rather than singly to better identify abuse. For example, California looks for recipients who are receiving a high number of abusive drugs from numerous providers and for emergency room use in conjunction with physician and outpatient visits.

Class Groups Screened Do Not Always Focus on Most Likely Abusers

SURS should also be programmed to focus on providers and recipients most likely to abuse Medicaid services. SURS was designed so that class groups of similar providers and recipients could be established, and individuals' use of Medicaid services could be measured against their peers. This better ensures that the utilization patterns of individuals identified as aberrant do in fact indicate potential abuse.

The SURS techniques manual recommends that recipients be classified, at a minimum, based on their age and whether they are institutionalized. In addition, recipients may be classified based on type of assistance qualifying them for Medicaid (such as Aid to Families With Dependent Children and Supplemental Security Income) or on geographic location. Providers, on the other hand, are classified according to demographic and medical characteristics. For example, they may be divided into such

[2]The services and parameters used were established through research of a SURS Operational Techniques Handbook prepared for the states to assist in the development of their utilization control programs and reports on state recipient control programs done by the National Governors' Association and Pracon, Inc.

[3]Appendix I provides details of our projections and cost avoidance estimates.

groupings as allergy and dermatology, radiology and radiation, urban or rural, and individual or group practice.

In 1978, we reported that problems in assigning providers and recipients to appropriate class groups and selecting class groups for screening adversely affected the validity of SURS reports. Many providers who appeared in Michigan's exception reports did so because they were put in the wrong class group. Similar problems were identified in Ohio's classification of recipients. We also reported that Michigan had obtained HCFA approval of its SURS by screening two recipient class groups for abuse, but had not screened other class groups.

Our current review showed that three of the six recipient control programs reviewed had used class groups inappropriately, thereby affecting the identification of potential abusers. In fiscal year 1985, Minnesota used class groups made up of the elderly and institutionalized almost exclusively, groups other states have found to be less likely to abuse Medicaid services. For example, Wisconsin believes institutionalized recipients lend themselves only minimally to review, and Texas and Ohio had eliminated or limited their review of elderly and/or institutionalized recipients because of the unlikelihood of finding abuse in those groups.

The supervisor of the Minnesota recipient surveillance unit said that Minnesota runs SURS primarily to meet the Systems Performance Review minimum requirement and did not try to select class groups based on the likelihood of identifying abuse. For example, he said that they have had the most success in identifying potential abusers from the 18-64-year-old Aid to Families With Dependent Children class group, but that group was screened only once for the four quarters we analyzed. In the fourth quarter of fiscal year 1985, Minnesota screened two class groups of recipients 65 years and older and one class group of residents in intermediate care facilities for the mentally retarded. Only 16 potential abusers were identified.

The supervisor of the recipient surveillance unit said that SURS was not the best method for identifying potentially abusive recipients and that he would rather rely on other sources[4] for referrals of abusive recipients

[4]The SURS unit receives referrals from its invoice processing unit, which identifies prescriptions filled for a recipient two or more times in one day, or from the next day, and from a state program to determine whether recipients are receiving rational drug therapy, which uses various screens to look at the appropriateness of physicians' prescribing practices.

than deal with the complexity of SURS. The other sources used by Minnesota primarily focus on abuse of prescription drugs. As discussed on pages 28 to 29, California had similarly focused its reviews primarily on abuse of codeine and had not identified about 4,700 recipients abusing such Medicaid services as emergency rooms and provider visits.

Louisiana also used class groups consisting primarily of institutionalized recipients in the four quarters we reviewed. In the first two quarters of calendar year 1985, the 14 class groups analyzed by the recipient SURS were all made up of institutionalized recipients. In the third quarter of fiscal year 1985, the state developed 13 new class groups, which include 10 made up of institutionalized recipients and 3 of noninstitutionalized recipients.[5]

Louisiana officials said they use these class groups because they want to identify potentially abusive providers treating institutionalized recipients. The preponderance of class groups with institutionalized recipients, however, could limit the state's ability to identify recipients abusing Medicaid services. As discussed above, other states have limited their review of institutionalized recipients because of the unlikelihood that they are abusing services. In Louisiana, however, institutionalized recipients in the 10 class groups screened are just as likely to be reviewed as recipients in the 3 class groups in which abuse is more likely to occur.

California also used class groups inappropriately. Until November 1984, California used only two class groups for recipients and limited the number of recipients that could be identified as potential abusers to 5,000 in each group. The system processed recipients on a county-by-county basis, progressing through the counties alphabetically. The head of the SURS unit noticed that when the system analyzed recipients from Los Angeles County, it reached the 5,000 limit and did not analyze potential abusers in counties that followed Los Angeles.

California has since developed 28 class groups, classifying recipients by four locations and seven types of aid qualifying them for Medicaid. All class groups are processed by SURS each quarter to assure coverage of the entire state.

[5]In the first two quarters of calendar year 1985, in which only institutionalized recipients were screened, 14,804 and 15,572 Medicaid recipients, respectively, were analyzed during the SURS identification process. In the next two quarters, in which Louisiana added class groups made up of noninstitutionalized recipients, 463,696 and 484,865 Medicaid recipients, respectively, were analyzed during the process.

According to California, since late 1984, it has also improved its screening process by eliminating those recipients least likely to abuse the program (people over 65 years of age, people in nursing homes, etc.) and those with severe conditions that may legitimately require a high level of care (diagnoses of cancer, chronic renal failure, congestive heart failure, etc.).

Controlling Output Is a Problem in Some States

SURS operates on the premise that if a provider's or recipient's use of Medicaid services deviates from established parameters, the individual is a potential program abuser. Selecting the proper parameters is important because it limits the number of providers or recipients identified as potential abusers. In 1978, we reported that the volume of SURS exceptions was more than available staff could handle and that no state we reviewed had arrived at what it believed to be correct control limits.

Our current review identified similar problems in controlling SURS output in Illinois and Louisiana. In Illinois, SURS identified an average of about 16,000 providers (about 59 percent of the state's providers) as potential abusers during each quarter of fiscal year 1985. A computer printout was produced profiling each of the 16,000 providers' billing records. Since the state was using only about 2 percent of the printouts produced each quarter, most of its output was shredded without review.

Louisiana focused its program on institutionalized recipients during the first two quarters of calendar year 1985. When the state developed class groups that included noninstitutionalized recipients (see p. 31), the number of potential abusers identified increased from 375 in the quarter April through June 1985 to almost 75,000 in the next quarter.

Officials in both Illinois and Louisiana said that they had limited experience in using SURS reports to control output. Methods for controlling systems output, however, were demonstrated in a Pracon, Inc., report[6] on utilization control programs.[7] We believe distribution of these types of

[6]An Analysis of Selected Medicaid Drug Utilization and Recipient Management Programs, April 5, 1984.

[7]The frequency distribution report shows the number and percentage of recipients using services screened at selected levels. Using frequency distribution from previous periods, a state could control the approximate number of recipients a screen will identify by setting the exception parameter at the utilization level that has previously excepted the approximate number of potential abusers desired; i.e. if a state wanted a screen to identify about 1,000 potential abusers, and frequency distribution reports from previous periods showed that about 1,000 recipients excepted above a specific utilization level for that screen, the exception parameter would be set at that level.

reports to the states by HCFA would help states improve their control programs.

States having trouble controlling SURS output might also want to consider a simplified recipient identification process developed by Texas that reduces computer processing time. Texas Medicaid officials said that traditional SURS processing consumed too much computer time, was too expensive, and had too high an output volume. According to Ohio, it is experiencing similar problems and has proposed a modification of its Medicaid Management Information Systems. It said that HCFA has been cooperative in reviewing its requests.

The traditional SURS process compares individual profiles to peer group profiles to identify individuals whose utilization differs significantly from peer group averages. The Texas system eliminates these comparisons and identifies the top 10 percent of the recipients utilizing specific services that the state has identified as indicators of potential abuse. While Texas' system has the capability to rank recipients in 99 separate service categories, state agency officials are currently using 2 that they consider to be the best indicators of recipient abuse.[8] Rather than build peer group profiles on all possible utilization screens, Texas identified recipients with high utilization patterns for these two services as potential abusers.

HCFA Does Not Provide Adequate Technical Assistance

The continuing problems states are having in identifying potential abusers and controlling SURS output highlights the need for technical assistance. The 1980 amendments to the Social Security Act require HCFA to provide states technical assistance in developing and improving their Medicaid Management Information Systems in order to continually improve the ability of state systems to detect abuse.

An official in HCFA's Bureau of Program Operations said that in the past HCFA sponsored Medicaid Management Information System conferences that covered SURS. However, the last time SURS was covered was in the 1983 conference. He said HCFA resource problems would not allow it to sponsor this type of conference in 1985 and that under current dollar constraints, there are no resources to provide more assistance to the states. He said states can get technical assistance for their Medicaid Management Information System on an ad hoc basis by asking the right questions to the right person. He said, however, there are no organized

[8]Number of office visits and number of emergency room visits.

technical assistance activities in HCFA to assist states in operating their SURS.

An official in HCFA's Division of Medicaid Procedures responsible for certifying state management information systems said his division plays only a limited role in assisting individual states to make better use of their SURS. He told us that HCFA has no system to transfer "best practices" from one state to another and that HCFA maintains no baseline information on state recipient control programs that would allow them to be compared and evaluated.

HCFA officials in the regional offices we visited also limited their technical assistance roles in the states. An official in the Dallas Regional Office said that although the office sponsored a meeting of states' utilization control officials to exchange information on their programs, it does not have a program to systematically provide technical assistance to states on how to make their utilization control programs more effective or on operating SURS. One official in the Dallas region stated that four of the five states in that region did not have staff that were knowledgeable about SURS. He said they lack the necessary system, statistical, administrative, and medical skills, and as a result, SURS data are not used as effectively as they could be to identify and monitor recipients and providers. The San Francisco HCFA regional official responsible for Systems Performance Reviews said he does not provide technical assistance to the states because he believed this was a function of HCFA headquarters.

Ohio Medicaid officials told us that they could have used technical assistance in setting up their recipient control program. The state's current recipient control program was set up in 1984 to concentrate on abuse of prescription drugs, and the same five screens have been used since March 1984. Ohio is now installing an updated SURS, similar to systems used in 14 other states.[9] State officials said they will experiment with different screens and different combinations of screens once the new system is installed. In commenting on a draft of this report, Ohio said that the HCFA regional office provided the names of people in other states who were developing new approaches to SURS, but more technical assistance is needed.

[9]In commenting on a draft of this report, Ohio said that it has completed installation of its updated SURS and has since installed a new Medicaid Management Information System. Ohio said that it will not be able to fully utilize the new SURS until problems in merging the two systems are resolved.

Although HCFA headquarters officials recognize that some states are not properly using SURS, officials in the Bureau of Program Operations say that limited resources hamper their ability to provide technical assistance.

Compared to the cost of establishing and operating Medicaid Management Information Systems—$430 million in 1985—the cost to provide technical assistance to improve the operation of those systems is minimal. For example, HCFA could have

- helped Louisiana and Illinois control the output of their SURS by giving them a copy of the Pracon, Inc., report discussing the use of frequency distribution reports;
- helped Minnesota and Louisiana in selecting appropriate class groups by providing data on the types of recipients most likely to abuse services;
- updated and distributed the 1973 SURS manual; and
- sponsored conferences of states' SURS officials to facilitate the exchange of techniques.

Review Requirement Should Be Revised

In 1982 we reported that states could generally meet most HCFA review requirements by making minimal use of SURS data. Although HHS is required to periodically update them, the review requirements have remained the same since the fiscal year 1983 Systems Performance Reviews. As a result, some states continue to make minimal use of SURS data.

By establishing a review requirement based on an assessment of states' potential abuse, HCFA could better ensure that SURS data are used efficiently and that adequate staff and resources are devoted to combating Medicaid abuse. It would also give HCFA reviewers more definitive criteria to better evaluate states' effectiveness in identifying and correcting abuse.

Review Requirement Inadequate

A 1973 SURS operational techniques manual explained that states' utilization review programs should be established on the basis of the potential abusers identified by reasonable identification criteria and that identification criteria should not be adjusted to limit output in accordance to the size of a state's staff. It warned that an investment in Medicaid computerization is largely wasted if SURS staffing and resources are inadequate, and advised that caution must be used to guard against the implementation of a sophisticated, full-blown computerized SURS that

will be used at only a fraction of capacity if staffing levels are inadequate.

In 1978, we reported that it was questionable whether any of the three states we reviewed had adequate staff to handle their workload. We noted that often reports that were produced were little used. For example, Ohio identified thousands of recipients potentially abusing Medicaid services, but seldom used the reports to identify abusers. HCFA reinforced the importance of adequate staffing in the 1982 SURS General Systems Design, which pointed out that the effective use of SURS reports is predicated upon the existence of an adequate staff to handle the workload generated by the system.

We reported in 1982, however, that states can generally meet most of the Systems Performance Review requirements for SURS by investigating a minimum number of recipients and providers and demonstrating that the SURS output was used. The Systems Performance Review requires that states review at least 0.01 percent of the total body of active recipients and 0.5 percent of the total number of active noninstitutional providers quarterly.[10] At least 80 percent of the established minimum recipients or providers to be reviewed must be selected from those identified through the ongoing quarterly SURS exception process.

Discussions with HCFA headquarters officials indicate that the requirements were established to assure at least a minimal use of the system, not as measures of efficiency. An official in HCFA's Bureau of Quality Control commented that before the Systems Performance Review, some states were not using SURS data, and that by developing the review requirements, they hoped to get states to use SURS at least to a minimal extent.

Minnesota, Wisconsin, and Louisiana were using the minimum Systems Performance Review requirement as the basis for their reviews of recipients identified as potential abusers by SURS. Table 3.1 presents data from four states on the number of recipients identified by their SURS as potential abusers, the number of those recipients reviewed during four quarters of SURS activity, and each state's Systems Performance Review requirement.

[10]A minimum number of inpatient hospital services providers must also be reviewed as specified in the Systems Performance Review on an annual basis.

Table 3.1: Number of Potential Abusers Identified and Reviewed in Four States, and the Systems Performance Review Requirement

States[a]	Time period	Potential abusers		Review requirement[c]
		Identified	Reviewed[b]	
California	1st quarter 85	41,452	3,406	338
	2nd quarter 85	43,167	4,156	338
	3rd quarter 85	25,972	4,000	338
	4th quarter 85	38,880	3,704	338
Minnesota	1st quarter 85	121	75	36[d]
	2nd quarter 85	2,201	31	36
	3rd quarter 85	256	30	36
	4th quarter 85	16	47	36
Wisconsin	3rd quarter 84	30,019	92	47
	4th quarter 84	29,749	91	47
	1st quarter 85	25,140	86	47
	2nd quarter 85	21,039	69	47
Louisiana[e]	1st quarter 85	353	459	42
	2nd quarter 85	375	526	42
	3rd quarter 85	75,836	434	42
	4th quarter 85	39,195	406	42

[a]Comparable data were not readily available in Texas and Ohio. In Texas the state plans to take action on 1,500 of the approximately 3,000 to 4,000 potential abusers identified each month; its quarterly fiscal year 1985 review requirement was 76. Ohio's exception listing is produced every 6 months and contains approximately 18,000 recipients, of which the state reviews about 1,200 cases each quarter. The quarterly review requirement in Ohio was 105.

[b]When the number of potential abusers reviewed is larger than the number of abusers identified, the additional potential abusers would be from other sources or previous SURS listings.

[c]Systems Performance Review requirement based on the states' Medicaid populations in fiscal year 1985.

[d]In commenting on a draft of this report, Minnesota said that the review requirement should have been 26 based on its active recipient count of 258,000. Our requirement of 36 was based on HCFA's 1985 census data for active recipients.

[e]In Louisiana, although more than the minimum number of recipients were being reviewed, HCFA determined the reviews were not acceptable because they focused only on one type of abuse.

In Minnesota, the head of the state utilization review unit told us the major reason the state runs the recipient SURS is to qualify for full federal financial participation. Minnesota limits its review of potential abusers identified by SURS to the Systems Performance Review minimum. He does not believe the SURS identification process is effective, and relies more on other sources to identify potential abuse. As discussed on page 31, the other sources used by Minnesota primarily focus on one type of abuse—prescription drugs.

For the four quarters of activity we reviewed in Wisconsin, the state reviewed an average of 85 potential abusers. As shown in table 3.2, most potentially abusive recipients in the two class groups (Aid to Families With Dependent Children and Supplemental Security Income-

Disabled) identified by the state as most likely to contain Medicaid abuse were not reviewed.

Table 3.2: Recipients in the Aid to Families With Dependent Children and Supplemental Security Income-Disabled Class Groups in Wisconsin Identified as Potentially Abusive During Selected Periods

	Recipients identified	
Services screened	2nd quarter	7/84-9/85
12 or more high-abuse prescriptions	288	1,790
500 or more high-abuse pills	755	3,760
300 or more codeine pills	218	1,301
91 or more days' supply of codeine	97	737
300 or more valium pills	218	1,201
91 or more days' supply of valium	327	1,691
5 or more pharmacies	36	488
12 or more physicians	67	564
5 or more prescribers	552	3,410

Louisiana reviewed an average of 456 potential abusers identified by SURS in the four quarters covered by our review. HCFA determined, however, that the reviews did not meet the Systems Performance Review requirement because they were conducted by peer utilization review committees established to review only drug utilization, and may not identify other types of abuse indicated by SURS data. Also, information from SURS summary reports, such as recipient's age, diagnosis, and place of service, were not being used by the committees to determine if the case justified full review. The cases were counted as committee reviews as long as the recipient was still Medicaid eligible and had not been reviewed before.

Louisiana is setting up a new procedure to satisfy the Systems Performance Review requirement. The state utilization control unit will select a sample of cases sent to the peer utilization review committees large enough to meet the recipient review requirement[11] and include SURS documentation in the case file. State officials said case files have been established on recipients with little chance of being restricted, such as critically ill recipients, just to ensure that enough files are available for the Systems Performance Review. In cases where the potential abuse is drug related, the peer utilization review committees will review the case.

[11]In the three quarters reviewed by HCFA for the fiscal year 1986 Systems Performance Review, the review requirements were 38 in one quarter, and 42 in two quarters. Louisiana met these requirements by performing reviews meeting Systems Performance Review standards in 84, 46, and 49 cases, respectively, in those three quarters.

For other types of potential abuse, the state utilization control unit will review SURS documentation to make a determination.

As shown in table 3.3, by performing only the minimal number of reviews required by the Systems Performance Review, many recipients in the class group "noninstitutionalized recipients, aged 21-64" utilizing high levels of Medicaid services were not reviewed in the third quarter of 1985.

Table 3.3: Recipients in the 21-64-Year-Old Non-Long-Term Care Class Group With High Utilization Rates During the Third Quarter of 1985 in Louisiana

	Recipients identified as potential abusers	
Services screened	Number	As a percent of recipients in the class group
5 or more different physicians	2,097	3.9
4 or more different prescribers	1,671	2.7
4 or more different pharmacies	1,150	1.6
18 or more prescriptions	5,500	7.7

Assessing Potential Abuse Would Provide Basis for Standards

In our 1982 report, we recommended that HCFA revise the Systems Performance Review standards to measure the states' effectiveness in identifying and correcting program abuse. In a December 6, 1982, letter to us, the Secretary of HHS disagreed with our recommendation, saying that such standards could not be implemented without information on the potential universe of program abuse.

While we agree with the Secretary that establishing fair and adequate program effectiveness measures depends on information on the extent of potential program abuse, we believe SURS has the capability to provide such an assessment. Reasonable identification criteria could be developed based on the most likely types of abuse, such as doctor shopping and excessive use of prescription drugs and emergency rooms. Consistent SURS screens, such as the number of different physicians or emergency rooms a recipient visits and the number of prescribing physicians a recipient has, could be used by all states as indicators of abuse. Exception criteria, such as 2.5 or 3 standard deviations above the norm, could be used as parameters to identify the number of potential abusers of the services selected.

HCFA would then have consistent data on a state-by-state basis on the extent of potential abuse as defined by the reasonable identification criteria. The Systems Performance Review requirement could then be set at that level or some percentage of it.

We realize that some states have placed limitations on certain services that may preclude those services from being abused. The assessment of potential abuse should identify little abuse of those services on which there are limitations. The criteria would therefore establish a state's review requirement based only on services likely to be abused. A more realistic review requirement may induce states to develop more efficient means to deal with potential abusers identified by their SURS.

Internal Control Weaknesses Should Be Corrected

The Federal Managers' Financial Integrity Act of 1982 requires that agencies periodically evaluate their internal control systems and that the heads of executive agencies report to the Congress annually on their systems' status. The reports are to state whether systems meet the objectives of internal control and conform to the internal control standards GAO established. Where internal control systems are not adequate, the agency report must identify the weaknesses involved and describe the plans for corrective action.

The standards for internal controls in the federal government require that internal control systems provide reasonable assurance that the systems' objectives will be accomplished. In judging whether a system provides reasonable assurance, agencies should, according to the standards

- identify (1) risks inherent to agency operations, (2) criteria for determining low, medium, and high risks, and (3) acceptable levels of risk under varying circumstances and
- assess risks both quantitatively and qualitatively.

Another standard requires managers to (1) promptly evaluate findings and recommendations reported by auditors, (2) determine proper actions in response to audit findings and recommendations, and (3) complete, within established time frames, all actions that correct or otherwise resolve the matters brought to management's attention. The audit resolution process begins when the results of an audit are reported to management and ends only after action has been taken that (1) corrects identified deficiencies, (2) produces improvements, or (3) demonstrates the audit findings and recommendations are either invalid or do not warrant management action.

Our November 1985 report on HHS's second year implementation of the act found that HCFA's internal controls over benefit payments made under the Medicare and Medicaid programs were not adequate. We reviewed 21 HCFA monitoring programs, including the Systems Performance Review, used by HCFA to review the performance of paying agents (state Medicaid agencies and insurance companies). We found that the monitoring programs were not comprehensive in that they did not include essential evaluation steps and contained serious internal control weaknesses.

The report pointed out that HCFA's monitoring programs review paying agents' compliance with numerous requirements, many of which prescribe benefit payment control techniques. However, the programs often do not establish the relationship between the techniques to be used and the objectives they are intended to accomplish. As shown previously with regard to the Systems Performance Review, no data are collected on SURS contributions to program results, and the only performance criterion used to measure states' use of SURS is a requirement established to assure only a minimal use of the system.

HCFA performed a vulnerability assessment[12] of the Systems Performance Review in 1985 and determined that its overall vulnerability rating was low. HCFA's internal control officer changed the rating to moderate in view of our 1985 report. Those areas receiving a vulnerability assessment of either moderate or high are scheduled for an internal control review.[13]

The internal control review of the Systems Performance Review was performed in two HCFA regional offices and HCFA headquarters in fiscal year 1986. It concluded that HCFA headquarters and one region had procedures for the Systems Performance Review that provided reasonable assurance that the systems' internal control objectives were met. In the

[12]HHS defined a vulnerability assessment as a review of the susceptibility of an internal control area to loss or unauthorized use of resources, errors in reports and information, illegal or unethical acts, and/or adverse or unfavorable public opinion. A major goal of the vulnerability assessment process was to rank internal control areas' vulnerability to fraud, waste, and abuse. The ranking was to be used in scheduling areas for more detailed internal control reviews.

[13]HHS defined an internal control review as a detailed examination of an internal control area to determine whether adequate control techniques existed. HHS initially required highly vulnerable areas to be reviewed during 1983 and all other areas within 5 years. HHS's internal controls manual issued in February 1985 removes the 5-year requirement. HHS guidance provided that reviews, such as those performed by us and the Inspector General, and those ongoing by management, may be substituted for internal control reviews, provided they meet internal control requirements or could do so with minimum modifications. Internal control officers were responsible for determining whether substitutes were acceptable.

other region, it concluded that the internal control procedures for the Systems Performance Review area did not provide the same reasonable assurance.

The internal control reviews, however, looked only at the Systems Performance Review process. In the regions, the internal control reviews looked at whether the Systems Performance Reviews were conducted in accordance with approved guidance. In headquarters, the internal control review evaluated the concept and design of the Systems Performance Review, its development, and the Medicaid Management Information System reapproval process.

The internal control review did not evaluate specific Systems Performance Review guidelines, and regarding the SURS component, whether they adequately ensure that state systems are being used in the most effective manner to identify and correct abuse. Based on the results of our work, we believe deficiencies in those guidelines still need to be addressed in order to adequately ensure that SURS is being used effectively and efficiently by the states to identify and correct Medicaid abuse.

Internal Control Weaknesses Should Be Included in Reporting and Tracking System

Our 1985 report recommended that the Secretary of HHS direct the HCFA Administrator to include internal control weaknesses identified by HCFA's benefit monitoring programs, as well as those identified in our reports and those of the Inspector General, in the Federal Managers' Financial Integrity Act's reporting and tracking system. The Secretary did not agree, stating that to be included in the act's reporting and tracking system, weaknesses should fit HHS's definition of a material weakness or be identified as a result of an internal control review or vulnerability assessment. We stated then, and continue to believe, that no matter how the benefit payment weaknesses are identified, HHS should include them in the reporting and tracking system to provide adequate assurance that they are monitored and corrected.

Conclusions

HCFA's Systems Performance Review neither adequately assesses states' SURS identification processes nor ensures more than a minimal use of SURS data identifying potential Medicaid abusers. Also, HCFA is not routinely providing states technical assistance to deal with SURS problems they face or disseminating information on successful SURS techniques.

A state's efforts to identify and review potential abusers should be commensurate with the extent of potential abuse in the state. By requiring each state to assess the extent of its potential abuse problems using the same HCFA-defined identification criteria, HCFA could develop Systems Performance Review standards to (1) better evaluate the effectiveness of states' screens, parameters, and class groups used to identify potential abusers and (2) better ensure that review requirements, and the staffing and resources necessary to meet them, are more commensurate with states' potential abuse problems.

HCFA should also collect data from states that would enable it to monitor SURS impact on program results. Considering that annual Systems Performance Reviews will no longer be required in each state, this information could be used by HCFA to better target states for review, and as further indicators of states needing technical assistance and using innovative SURS techniques. We also believe that including benefit payment internal control weaknesses in the Federal Managers' Financial Integrity Act's reporting and tracking system will better assure that those weaknesses are addressed.

Recommendations

We recommend that the Secretary of HHS instruct the HCFA Administrator to:

- Require states to annually assess the extent of recipient and provider abuse in the state using a set of HCFA-developed identification criteria.
- Revise the Systems Performance Review to link a state's assessment of its potential abuse problems to the number of potential abusers that the state must review to meet review requirements.
- Revise the Systems Performance Review to include specific evaluations of how effectively states use SURS to identify potential abusers. Specifically, the review should determine if a state's screens and class groups are reasonable in view of the potential abuse identified in the annual assessment and if parameters are reasonable in light of the review requirement.
- Include in the Systems Performance Review guidelines a requirement to document (1) technical problems states are having using the SURS to identify Medicaid abusers and (2) successful SURS techniques developed by states to identify, review, or sanction Medicaid abusers.
- Establish procedures to provide technical assistance to states experiencing problems using SURS and periodically identify, evaluate, and disseminate information on innovative SURS techniques to states for their consideration.

- Collect annual data on program results to monitor states' utilization control programs and use those data in determining which states will be subject to Systems Performance Reviews, and as additional indicators of (1) states needing technical assistance and (2) states using successful SURS techniques.
- Include Medicaid postpayment utilization review program deficiencies as material internal control weaknesses in the Federal Managers' Financial Integrity Act's reporting and tracking system.

HHS Comments and Our Evaluation

HHS (see app. II) said that although it did not agree that current state practices are necessarily deficient or that the Systems Performance Review process is the best vehicle for federal oversight, it plans to work cooperatively with the states in two areas.

First, according to HHS, it will explore why states have structured their utilization review programs the way they have. Second, HHS said it will compile an inventory of states' "best practices," which could be of widespread interest among the states. The states, rather than HCFA, are likely to be able to provide the most useful guidance in this area, and according to HHS, states tend to be more receptive to guidance from their peers.

Finally, HHS said that in carrying out its proposed initiatives in the coming year, it expects to consider what federal requirements are desirable and what mechanisms, including the Systems Performance Review, are best suited to defining and enforcing them.

While we are encouraged by HHS's plans to compile an inventory of states' best practices, its comments do not address our specific recommendations or provide details on how or when it plans to take the actions outlined. Further, we disagree with HHS's suggestion that current state practices may not be deficient. We believe the problems in selecting screens and class groups and controlling SURS output discussed in chapter 3 demonstrate deficiencies in state programs. In addition, the limited number of potential abusers reviewed in Wisconsin, Minnesota, and Louisiana compared to the number of potential abusers identified shows that SURS is not being used effectively to identify and correct abuse.

We continue to believe that states should be required to do more to identify and correct abuse. While there may be alternative ways to set such requirements, we believe HHS should do more in the next year than just "consider what federal requirements are desirable."

Rationale for Criticisms

HHS said that our report criticizes Wisconsin for following up on only 69 of the 21,000 recipients identified as potential abusers while criticizing Illinois for producing too long a list of abusers. HHS also said that we criticize Minnesota and Louisiana for focusing their reviews on the elderly and institutionalized individuals. We do not, HHS says, explore the rationale for the state's practices.

We do not agree. In the case of Wisconsin, we pointed out on page 36 that the number of potential abusers it reviews is a function of the HCFA requirement that 0.01 percent of active recipients be reviewed each quarter, not on an analysis of the state's potential abuse problems. In the case of Illinois, we pointed out on page 32 that Illinois officials said that their limited experience in using SURS reports to control output caused the problem of identifying about 59 percent of the state's providers as potential abusers.

In Minnesota and Louisiana, we questioned the reasonableness of their practices of focusing on elderly and institutionalized recipients based on both the limited number of abusers identified in those states and the opinions of officials in other states that there is a low potential for abuse among those populations. As discussed on pages 30 to 31, Minnesota was processing elderly and institutionalized populations in two quarters as a means to meet minimum Systems Performance Review criteria, and Louisiana was processing them as a means to identify potentially abusive providers treating nursing home patients. As a result, in neither case was SURS being used effectively to identify recipient abuse.

We recognize that our review did not establish how many recipients should have been reviewed in Wisconsin, how many providers should have been identified in Illinois, or the types of recipients most frequently abusing services in Louisiana or Minnesota. We were unable to make such determinations because neither HCFA nor the states had assessed the types and extent of potential abuse in the states or set review requirements based on those assessments.

Internal Control Weaknesses

HHS said that it does not, at present, believe that the kinds of postpayment utilization review program deficiencies cited in our report reflect "material" internal control weaknesses as defined by the Federal Managers' Financial Integrity Act. Reporting of the deficiencies under the act would not, in HHS's opinion, be appropriate.

We did not intend to suggest that HHS report weaknesses in individual states' utilization control programs as material internal control weaknesses. Rather, we believe HHS should identify as a material weakness its oversight of postpayment utilization review activities. HHS should do this until the recommendations contained in this report are implemented or other appropriate actions are taken to better ensure that states operate effective utilization control programs.

States Visited Do Not Reflect Situations in All States

HHS does not believe that the sample of states included in our review reflects the general state of Medicaid Management Information System development nationwide. California and Minnesota, for example, utilize state-of-the-art computer systems, and not many states have such capabilities.

We recognize that significant variations exist in the capabilities of individual state computer systems. We believe, however, that HCFA oversight should ensure that each state uses its system to the fullest potential. For example, Minnesota should expand the use of its state-of-the-art system to more effectively support the utilization control program. As discussed on pages 28 and 31, California has already taken steps to expand the number of screens and class groups used to identify potential abusers.

Medicaid Fraud Control Units Considered

According to HHS, our report does not appear to take into account the efforts of state Medicaid fraud control units operating in about 38 states. The units, HHS said, may be an integral part of a state's administrative efforts to follow up on Medicaid Management Information System data. As discussed on page 13, we recently completed a separate review of fraud control units and therefore excluded them from this review.

State Comments and Our Evaluation

California, Louisiana, Massachusetts, Minnesota, Ohio, and Wisconsin provided comments on a draft of this report. Their comments and our evaluation follow. Illinois and Texas were also given the opportunity to comment, but had not done so when this report was finalized.

California Comments

California (see app. III) said that our report makes some unreasonable comparisons between states. According to California, differences in state systems exist—in benefit structures, in prepayment controls, in all

aspects of the adjudication process, as well as in the postpayment utilization review function itself—that have an effect on the types of postpayment reviews that are appropriate. California said that these differences may cause otherwise unexplainable differences in the operation of the postpayment functions.

We recognize that differences exist between states, but do not believe we have made unreasonable comparisons. The deficiencies we cite in the operation of state programs are based on an evaluation of that state's screens, class groups, and methods for controlling output, not by comparing them to other states.

California said that it objects very strongly to our recommendation that HCFA require states to assess the extent of abuse using HCFA-developed criteria. According to California, one set of postpayment abuse criteria cannot fit every state's needs, nor can it be used to compare states' performance. California also disagreed with our recommendations that minimum review criteria can be based on an assessment of the extent of potential abuse in the state and that the Systems Performance Review be used to evaluate how effectively states use SURS to identify potential abusers. California questioned how the Systems Performance Review would determine the reasonableness of such things as screens, class groups, and parameters.

Our recommendation is intended to give HCFA baseline data for assessing the effectiveness of states' postpayment utilization review programs, not to set criteria that states must use in their identification process. If, for example, the uniform screens showed that abuse of emergency room services was the most prevalent type of abuse in California, HCFA could use this information in determining whether California was using appropriate screens in its SURS program. Similarly, if California focused its reviews on class groups of recipients that were shown by the uniform criteria to exhibit little potential for abuse, HCFA would have a basis for questioning the reasonableness of those class groups. Finally, differences in state programs in terms of benefits covered, prepayment controls, etc., would automatically be factored into the assessment, reducing the amount of potential abuse identified and therefore the review requirement.

California questioned whether the $4 million potential savings we estimated were in addition to savings they were already achieving. In the quarter we analyzed, the state was still using a limited number of screens, and our objective was to determine if additional abusers could

be identified. The recipients we identified had not been identified by the state screens, and the estimated $4 million was in addition to existing program savings. California has greatly expanded its use of screens and combinations of screens since our initial visit, and we believe this has improved the effectiveness of the recipient screening process. Concerning the cost-to-benefit ratio for screening additional potential abusers, we would consider the 4-to-1 ratio suggested by the state as supporting the cost-benefit of screening additional recipients.

Ohio Comments

Ohio (see app. IV) said that it has already installed many of the improvements that we are recommending and noted some other approaches being used in other states that it plans to explore. Ohio said it agrees with many of our points regarding the need for more sharing of information and technical assistance from HCFA, but that limited resources at all levels of government can affect what is possible.

Ohio expressed concern over what methodology would be used to identify the extent of abuse and the standards that might result for a state's review activity. The benefit of review activities should, Ohio said, be evaluated against the cost. According to Ohio, each state's program is geared to the size of the Medicaid population, the number of providers, the standard of medical practice, and state laws, rules, and regulations. It is unrealistic, Ohio said, to expect that what works in Wyoming will necessarily work in Ohio. Ohio suggested that a range of acceptable performance trade-offs between program methodology be evaluated. There is a danger, according to Ohio, in establishing a single standard for the nation, as it may limit a state's ability to test an innovative monitoring approach.

As discussed above, the uniform criteria we are recommending are intended to develop baseline data that HCFA can use in assessing the adequacy of a state's efforts to identify and correct abuse. The states would not be limited to use of such criteria in their SURS programs, and we would not expect them to use a screen in their program if the HCFA uniform assessment identified low potential for abuse of that service. We are recommending that review criteria be based on an assessment of the extent of potential abuse in the state in order to factor in such things as prepayment controls and noncovered services, which can reduce the potential for abuse. The current procedure of basing the review requirement solely on the number of Medicaid recipients in a state does not attempt to adjust for other variables that could increase or decrease the potential for abuse. Under the review criteria we envision, a state with a

large elderly and/or institutionalized Medicaid population with low potential for abuse would have a lower review requirement than a state with a large AFDC population and no prepayment controls.

Additional Ohio comments have been incorporated in the body of the report where appropriate.

Louisiana Comments

Louisiana (see app. V) said that from its standpoint, the findings of our report are basically fair. According to Louisiana, it has been hoping for the development of a more appropriate mechanism to measure the effectiveness of SURS. Louisiana said that it has concerns about the current Systems Performance Review, which focuses primarily on the investigative nature of the case review process. It suggested that the state technical advisory group could look further into developing a review process that considers SURS performance in greater detail than is now done.

Regarding HCFA technical assistance, Louisiana said that while ongoing technical assistance would be of enormous help in fine-tuning its SURS system, neither the HCFA Dallas Regional Office nor the central office was able to grant the state's request for technical assistance. The training and technical assistance secured by Louisiana came, the state said, from a private consulting firm.

According to Louisiana, it has service limits on many Medicaid services that serve as front-end controls to limit recipient abuse. As a result, Louisiana said, there is more concentration by the SURS unit on services which have no front-end control and must be monitored by a postpayment review. Louisiana said that its lock-in program espouses an educational philosophy that it is necessary to protect the recipient from overutilizing drugs by lock-in or by a network of provider communication initiated by four regional peer utilization review committees under contract to its fiscal intermediary. According to Louisiana, much of the committees' intervention results in a change in drug utilization without locking the recipient in. Louisiana said it is identifying savings from this type of intervention and lock-in.

Louisiana said that declining state revenues have resulted in a reduction to Medicaid services as well as staff. According to Louisiana, the loss of staff, especially in the SURS unit, has resulted in the state contracting with a fiscal intermediary to perform SURS functions. Louisiana said that contracting with a fiscal intermediary resulted in cost savings to the state due to the enhanced matching rate of 75-25 rather than 50-50

when the function was performed in-house. The contract and cost savings are based on minimum numbers of Systems Performance Review cases plus complaint cases that the fiscal intermediary must review. Any increase in the number of cases could, Louisiana said, negatively affect the state by increasing the cost of the contract.

Louisiana said that even the minimum number of cases it is required to review to meet the Systems Performance Review requirement is sometimes difficult to meet if there are insufficient staff available to manage SURS. It said that fine-tuning the parameters of the control file can cause the most aberrant cases to "except," and some state criteria are necessary in order to choose, from among the exceptions, cases that can be investigated within staff limitations. Louisiana recommended that it continue to have state control over the cases selected for review.

We agree. Our recommendation to assess the extent of potential abuse and set minimum review requirements using HCFA-developed criteria was not intended to limit the states to those criteria in operating their SURS unit. States would continue to have control over the screens they use to identify potential abuse. HCFA would use the data from the uniform screens to determine whether states were appropriately focusing their postpayment utilization review programs on the types of abuse most prevalent in the state.

As discussed on page 35, an investment in Medicaid computerization is largely wasted if SURS staffing and resources are inadequate. We recognize that requiring the fiscal intermediary to review more than the minimum number of cases required by the Systems Performance Review would decrease the state's "cost savings," under the contract, but believe the increased cost would be more than offset by the cost savings that might result from better controlling Medicaid abuse.

Wisconsin Comments

Wisconsin (see app. VI) agreed with our findings that the SURS system is not being effectively used, but said that it believes that the problem is not the review criteria used in the Systems Performance Review, but the entire approach. According to Wisconsin, states should be given the option of setting up an alternative review system that uses a more targeted approach rather than the random sample/exception type of system currently required. This methodology, Wisconsin believes, would allow it to better direct its limited resources to the areas that would be most cost/beneficial.

Wisconsin suggested an alternative system that would target potential abuse based on a more exacting peer grouping, which uses not only provider characteristics but also recipient and disease characteristics. According to Wisconsin, these groups would be defined using 24 months of paid claims data that are used to array the chosen characteristics. These "profiles," Wisconsin said, would be reviewed by medical personnel to insure that the data were reliable and to interpret any outliers.

Wisconsin said these profiles could be used to construct a "logic tree," which would use the extracted claims that met the profile criteria and further refine the final extracted data showing actual claims that were characteristic of abuse or fraud. This more targeted and automated approach would save manual effort on the part of audit staff and allow the state to focus on areas of large expenditures and questionable medical practices.

HCFA has, according to Wisconsin, allowed states this option in the Systems Performance Review for the Claims Processing Analysis System. Wisconsin said that it has found its own alternative system to detect errors that could not be detected under the mandatory random sample methodology. A similar targeted approach in SURS would, Wisconsin said, probably yield far better results than the currently required system.

While Wisconsin's suggested alternative approach may have merit, other states, such as Texas, California, and Ohio, have been able to effectively use SURS to target potential abuse. While Wisconsin may wish to pursue with HCFA the development of an alternative system, until such a system obtains HCFA approval, we believe Wisconsin should focus its efforts primarily on ways to more effectively use the existing SURS system. The problem in Wisconsin has primarily been one of inadequate resources assigned to review of potential abusers, not problems in the identification system. Accordingly, we think that a change in the review criteria to require more than minimal use of SURS data would be appropriate. Developing an alternative method to identify potential abusers will not be effective unless the state is willing to devote sufficient resources to review the potential abusers identified.

Minnesota Comments

Minnesota (see app. VII) said that our report focuses too narrowly on the scope of the SURS activity. SURS is but one resource used in Minnesota's commitment to the identification, vigorous action against, and prevention of abuse in the Medicaid program. According to Minnesota,

the report leaves the impression that, in the main, the remedy for controlling abusive practice is to increase the federal standards and oversight for exception reporting. The "more is better" philosophy does not, Minnesota asserts, fit the SURS function. Minnesota said that it will continue to do more than what is minimally required by the Systems Performance Review, but did not identify any plans to expand its use of SURS data.

As discussed on pages 31 and 37, the other methods Minnesota uses to detect recipient abuse focus primarily on one type of abuse—prescription drugs. While these efforts may be effective in identifying and preventing abuse of prescription drugs, Minnesota has largely ignored the potential for abuse of other Medicaid services, such as doctor and emergency room visits. Similarly, it has not focused on the types of recipients it has found are most likely to abuse Medicaid services—18-64-year-old Aid to Families With Dependent Children recipients. The limited efforts by the state to combat Medicaid abuse underline the importance of establishing adequate federal review requirements based on an assessment of the extent of abuse in the state. The intent of our recommendation is not to require the state to shift resources from other methods to detect abuse, but to encourage the state to make more than minimal use of a state-of-the-art computer system paid for largely with federal funds.

According to Minnesota, exception reports generated from SURS indicate, rather than establish, abusive practices on the part of providers and recipients. Minnesota said that it is opposed to our recommendation to use SURS to establish estimates of potential abuse and set minimum review standards based on these estimates. The task of tailoring an individual potential abuse indicator to account for the variations in state programs would, Minnesota said, be monumental, exacerbated by the lack of federal resources.

As previously stated, differences among the states in such areas as prepayment controls and program benefits should be reflected in the levels of potential abuse identified when uniform screens are used. For example, if a state limits recipients to 8 prescriptions per month as a way to limit abuse, a screen to identify recipients who received 10 or more prescriptions in a month should identify no potential abuse in that state. Because the review requirement would be based on the amount of potential abuse identified, the minimum review requirement would be lower in that state.

The SURS techniques manual and the states' SURS units could be used as resources by HCFA to develop standard criteria without an inordinate commitment of resources, and the screens could be run once a year during normal SURS processing.

Minnesota said that the back-to-back runs of elderly and institutionalized persons referred to on page 30 was an error. Minnesota pointed out, however, that although restrictions rarely result from reviews of such recipients, it is not uncommon for referrals to be sent to the drug utilization review program, which sends educational letters to physicians and pharmacies regarding the drug regimen. According to Minnesota, the Systems Performance Review requires that all class groups be processed at least annually, and Minnesota runs some groups two or three times a year.

As noted on page 30, the supervisor of the recipient surveillance unit told us that Minnesota does not try to select class groups based on the likelihood of identifying abuse, and the group of recipients most likely to be abusing Medicaid services was screened only once during the year we reviewed.

According to Minnesota, our report places a great deal of emphasis on the lack of technical and program assistance provided by the federal agency. Minnesota said that it does not believe building such a capacity in HCFA would be more productive and suggested that HCFA could do more to make technical assistance available from the vendors that have developed and support the SURS systems through enhanced funding of routine, on-site vendor consultations.

Minnesota said that program expertise regarding innovative SURS techniques rests in the various state SURS units. According to Minnesota, the national association of SURS officials is an organization that grew out of the need to share information on SURS activities. The organization publishes a quarterly newsletter containing the type of information our report identifies as useful.

We believe HCFA is in the best position to provide technical assistance and information on best practices to the states. HCFA has the responsibility to oversee states' SURS and, in carrying out that responsibility, visits the states to carry out the Systems Performance Review. We believe this gives HCFA the opportunity to compare and evaluate SURS techniques in all states, providing a good perspective on whether techniques being used could be improved. We agree that technical assistance from HCFA

should be supplemented by networking among the states. HCFA could be a good catalyst for this type of activity if it played a more active role in gathering and disseminating pertinent information to the states. As discussed on page 44, HHS agreed that identifying and disseminating information on best practices would be an appropriate role for HCFA.

We agree with Minnesota that more extensive technical assistance should be obtained from the vendors who set up the state program. We do not necessarily agree, however, that enhanced federal funding should be provided to obtain such assistance. Enhanced funding is provided for developing the SURS system. We do not believe the federal government should assume a larger burden of training state employees to use it.

Massachusetts Comments

Massachusetts comments were received too late to be incorporated in the body of the report, but are included as appendix VIII.

States Try Different Techniques to Fight Provider Abuse

Although limited data were available on their effectiveness, we identified several methods used by states to control abusing providers. The techniques we identified included

- visiting providers suspected of abusing Medicaid services to discuss the problem area(s),
- sending education letters to providers who appear to be abusing services,
- manually reviewing claims submitted by abusing providers before payment,
- identifying overpayments without on-site audits, and
- basing sanctions on peer reviews.

By evaluating and disseminating information on provider control techniques, HCFA could help states develop comprehensive programs to combat Medicaid abuse.

Provider Education Visits

Texas uses education visits as a method to deal with potential provider abuse problems. If analyses of a case show potential abuse in a medical area, the associate medical director will visit the provider. If the area of abuse involves billing or coding problems, a provider relations representative will visit. The purpose of the visits is to alert providers that they are being monitored and to try to change their abusive billing practices.

During the education visit, the state representative and the provider discuss the areas in which possible abuse is occurring and remedial action that can be taken. The associate medical director or the provider relations representative reviews specific recipient records at the time of the visit, especially if a particular case seemed suspect or if several cases documented a blatant problem area. To ensure mutual understanding of points discussed during the visit, a letter highlighting these areas is sent to the provider. During the period July 1984 through June 1985, 318 education visits were made to providers.

Education Letters

Massachusetts has initiated an education letter program for providers who appear to be abusing Medicaid services but whose Medicaid income does not warrant a field audit. Massachusetts limits its field audits to providers whose Medicaid earnings exceed $10,000. The education letters are intended to provide some contact with providers whose Medicaid earnings were less than $10,000. Providers who exceed their peer group norms for targeted services will be sent a letter advising them

that their practice deviates from that of their peers. SURS data showing the providers where they rank relative to their peers and the potential excess payments they have received are included. The providers are told their billing practices will continue to be monitored and that they will be contacted again if warranted.

According to Ohio, it recently started a similar program using educational warning letters to alert providers that their billing profiles are exceeding the norm for their group.

Manual Prepayment Claims Review

California and Texas sanction providers who have been abusing Medicaid services by manually reviewing their claims for selected services before payment. Providers subject to this review must provide supporting documentation for the claim, which is reviewed by a nurse before payment.

Providers remain on manual prepayment review until the states determine they demonstrate their understanding of and willingness to comply with program requirements. They are evaluated periodically to see whether they can be removed from manual prepayment review or if they are abusing different Medicaid services. In fiscal year 1985, Texas and California had 288 and 299 providers, respectively, in their manual prepayment review programs.

In California we compared income levels for the four quarters before and the four quarters after manual prepayment claims reviews were initiated for the 47 providers for whom data were available. The average earnings per quarter before controls were $37,831, while the average earnings after controls were $11,531—an average quarterly decrease of $26,300.

Overpayments Identified Without On-Site Audits

Physicians are paid a higher fee for patient contacts involving more comprehensive services. Texas identifies and recoups overpayments from physicians for abuse of higher cost patient contacts without conducting field audits.

Texas has a policy stating that over 50 percent of patient contacts for all specialties should be routine. The policy provides guidelines to be used for coding claims that identify routine and over and above routine procedure codes for office visits, hospital visits, skilled nursing facility visits, nursing home visits, and emergency room services. Recoupment

of overpayments is based on the extent to which more comprehensive services exceed 50 percent. For example, a provider claiming 75 percent of his or her office visits above the routine level would have those claims cut back by 26 percent.

Using this approach, in fiscal year 1985 Texas initiated recoupment actions against 62 noninstitutional providers for a total of $225,980 and an average overpayment of $3,645.

In commenting on a draft of this report, Ohio said that Texas' practice of cutting back reimbursement without examining the evidence of need seems unfair and is not compatible with its Medicaid program. Ohio said that it does, however, make across-the-board adjustments on certain billing codes that are found to be not authorized or misbillings.

Peer Review

The chief of Illinois' Bureau of Program Integrity believes peer review has been the state's most successful method for terminating providers who are abusing Medicaid services. She believes it has been a success because physicians are reviewing other physicians' abusive practices and how they affect quality of care. The Peer Review Unit evaluates the medical necessity, quality, and appropriateness of Medicaid services rendered. Five medical professionals, who are recommended by the Illinois State Medical Society, act as consultants and are involved in the evaluation process.

Cases assigned for peer review are first referred to a member of the Peer Review Unit, and if quality of care issues are identified, an on-site review is conducted with a consultant. The on-site review report is presented to the Peer Review Committee, which formally recommends action to be taken on each case. Actions may include, but are not limited to, (1) closing the case, (2) educating the provider, (3) placing the provider on continuous monitoring, (4) suspending or terminating the provider from Medicaid, or (5) referring the case for further bureau action or to a professional society or law enforcement agency.

The Peer Review Section manager estimated that 60 to 70 percent of the providers whose abusive practices are coming before the Peer Review Committee are being terminated because those practices adversely affect quality of care. Of those cases going on to administrative hearings, she estimated that almost all (99 percent) have resulted in the committee's termination recommendations being upheld.

Methodology Used to Identify Recipients Abusing Medicaid Services in California

Our objective was to identify individuals in California's population of Medicaid-eligible recipients who were abusers of Medicaid services during the quarter April through June 1984. Initially, we identified potentially abusive recipients by using four screens we developed through researching the SURS Operational Techniques Handbook, and reports on state recipient control programs done by the National Governors' Association and Pracon, Inc. The screens, which were run against a 5-percent sample of individuals eligible for Medicaid during the quarter analyzed, identified 4,349 recipients as potential abusers. Table I.1 presents the screens and parameters used, the number of individuals identified by each screen, and the results of our projections to the universe of Medicaid-eligible individuals.

Table I.1: Projections of Potential Abusers Identified in California Using 5-Percent Sample of Medicaid-Eligible Recipients[a]

	Statistical confidence intervals at the 95-percent confidence level					
	Projection			Percent of total		
	Mid-point	Binomial		Mid-point	Binomial	
Screens and parameters used[b]	level	Lower limit	Upper limit	level	Lower limit	Upper limit
15 or more prescriptions (1,752)	35,040	33,491	36,659	1.9290	1.8437	2.0181
8 or more provider visits (669)	13,380	12,431	14,401	0.7366	0.6843	0.7928
3 or more emergency room visits (300)	6,000	5,375	6,698	0.3303	0.2959	0.3687
4 or more different providers (731)	14,620	13,626	15,685	0.8048	0.7501	0.8635
Exceed at least 2 screens (897)	17,940	16,837	19,115	0.9876	0.9269	1.0523
Total (4,349)	**86,980**	**84,554**	**89,472**	**4.7883**	**4.6547**	**4.9255**

[a]Universe size 1,816,523; sample size 90,826.

[b]Figures in parentheses are number of unduplicated individuals identified.

To identify actual abusers among the 4,349 potential abusers, a proportional subsample of 351 recipients was selected from that universe. We analyzed each case in the subsample to determine if the utilization of medical services was justified. The analyses were based on the recipients' age, diagnoses, and types of providers visited. Further review by our medical advisor and state utilization officials identified 19 cases as abusive. Table I.2 presents the types of recipient control, the number of abusers identified who should be placed under each control, and the results of our projections to the Medicaid-eligible population.

Table I.2: Projections of Recipients Judged to Be Abusing Medicaid Services[a]

	Statistical confidence intervals at the 95-percent confidence level					
	Projection			Percent of total		
		Binomial			Binomial	
Recipient controls[b]	Mid-point level	Lower limit	Upper limit	Mid-point level	Lower limit	Upper limit
Prior authorization (2)	496	139	1,754	0.0273	0.0076	0.0966
Monitor status (17)	4,213	2,624	6,695	0.2319	0.1445	0.3686
Total (19)	**4,708**	**3,006**	**7,300**	**0.2592**	**0.1655**	**0.4019**

[a]Universe size 4,349; sample size 351.

[b]Figures in parentheses are number of individuals identified.

We estimated cost avoidance based on studies conducted by the state of restricted recipients' use of Medicaid services before being restricted and their use of services while on restriction. Table I.3 provides our estimates.

Table I.3: Estimated Number of Additional Recipients Abusing Medicaid Services in California and Potential Cost Avoidance From Recipient Control

Type of recipient control	Estimated number of recipients[a]	Estimated cost avoidance	
		Monthly	Annual
Prior authorization	496	$160	$952,320
Warning letters	4,213	60	3,032,640
Total	**4,708**	•	**$3,984,960**

[a]Figures do not total because they are independent projections.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JAN 19 1987

Mr. Richard L. Fogel
Assistant Comptroller General
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report, "Medicaid: Improvements Needed in Programs to Prevent Abuse." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report,
"Improvements Needed in Programs to
Prevent Abuse"

GAO's report basically describes its assessment of programs to control Medicaid recipient abuse of services in six States (California, Minnesota, Ohio, Texas, Louisiana and Wisconsin) and provider abuse in four States (California, Illinois, Massachusetts and Texas). GAO's stated purpose was to determine whether States were effectively identifying Medicaid abuse and the extent to which sanctions were being imposed.

GAO explains that despite previously identified weaknesses in States' postpayment utilization review programs and the Department's oversight, effective action has not been taken to strengthen management controls. More specifically, according to GAO some States reviewed were not effectively using their computerized management information systems to identify potential Medicaid abuse and some were reviewing only a small portion of the potentially abusive recipients identifed. In addition, GAO reports that most States have sanctioned few abusive Medicaid recipients. Using different assumptions for the percentage of Medicaid recipients in control programs and annual savings per recipient, GAO estimates that potential cost avoidance in 1985 could have ranged from $54.5 million to over $400 million.

In view of these findings, GAO recommends that the Department: assess the extent of provider and recipient abuse in each State; establish minimum review requirements based on the results of the assessment; and, improve the States' use of their management information systems to identify potential abuse.

The Department shares and appreciates GAO's view on utilization review, through which States may target apparent abuses by individual providers or recipients and take appropriate action. However, we do not agree with GAO that current State practices necessarily are deficient, or that the Systems Performance Review (SPR) process is the best vehicle for Federal oversight in this field. For example, GAO cites Wisconsin for following up on only 69 of over 21,000 recipients identified as potential abusers in one quarter of 1985. At the same time, Illinois is faulted not for failing to follow up but for improper edits that produced too long a list of potential abusers. Minnesota and Louisiana are criticized for focusing their reviews on elderly and institutionalized individuals, groups GAO believes unlikely to abuse Medicaid services.

While GAO may be correct in concluding that many States' practices are deficient, its report reflects little effort to explore with the States the rationale for their practices. State utilization review screening and follow-up activities have been measured by our SPR for years. Rather than simply expand our requirements, particularly as assessed through the SPR, our plan is to work cooperatively with the States in two areas. First, we will explore why States have structured and used their utilization review programs the way they have. For example, we will determine the reasons for which Minnesota and Louisiana have focused on the elderly; and, the reason Wisconsin pursued so few potential abuser recipients in 1985.

Our second objective is to compile an inventory of State "best practices" which could be of widespread interest among the States. The most useful guidance in this area is likely to be available from the States themselves, rather than the Health Care Financing Administration (HCFA) and the States tend to be more receptive to guidance from their peers in any event. The "best practices" compendium HCFA previously prepared in the area of State third-party recovery techniques has been extremely well received by the States.

In the course of carrying out our proposed initiative in the coming fiscal year, we expect to consider what Federal requirements are desirable in this area and what mechanisms, including the SPR, are best suited to defining and enforcing them. At present, we do not believe that the kinds of postpayment utilization review program deficiencies discussed in GAO's report reflect "material" internal control weaknesses as defined by the Federal Managers' Financial Integrity Act (FMFIA). As such, we do not believe reporting under the FMFIA of any such deficiencies is appropriate.

In addition, we do not believe the sample of States which GAO uses reflects the general status of Medicaid Management Information System (MMIS) development nationwide. For instance, California and Minnesota utilize state-of-the-art computer systems in their MMIS; not many States have such capabilities and would find it difficult to duplicate the efforts of California and Minnesota.

In addition, GAO does not appear to take into account the efforts of State Medicaid Fraud Control Units (MFCUs). Approximately 38 States have MFCUs which utilize data from the MMIS system in carrying out their responsibility for investigating fraud and abuse in their respective State Medicaid programs. While the GAO report criticizes States' general lack of utilization of MMIS capabilities in preventing abuse, it fails to recognize that a MFCU may in fact be an integral part of a State's administrative efforts for follow-up on MMIS information.

Comments From the State of California

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

JUNE 1, 1987

Richard L. Fogel
Assistant Comptroller General
United States General Accounting Office
Washington, D. C. 20548

Thank you for the opportunity to comment on the draft report titled "MEDICAID: Improvements Needed in Programs to Prevent Abuse (Code 101099)" prepared by your office. Governor Deukmejian has asked that I respond directly to you on this since it is my office that is the subject of the audit.

Although the stated purpose of the audit is to review and assess the effectiveness of state programs in identifying and sanctioning Medicaid abusers, the recommendations resulting from the audit appear to be directed at the Health Care Financing Administration of Health and Human Services (HCFA). Many of the issues raised appear to be concerned with the GAO's perception of the role of HCFA in overseeing state MMIS systems. We prefer not to comment directly on these matters except insofar as we would be directly and adversely affected by any recommendation that might be implemented.

We also feel it is inadvisable for us to comment on the programs of other states, since we are not fully conversant with their systems. We do feel, however, that some unreasonable comparisons have been made between states. Differences in state systems exist - in benefit structures, in prepayment controls, in all aspects of the claims adjudication process, as well as in the postpayment utilization review function itself - that have an affect on the types of postpayment reviews that are appropriate. Such differences may have been beyond the purview of this audit, but need to be considered because they may cause otherwise unexplainable differences in the operation of the postpayment functions.

Our comments, which are attached, are focused on a few specific issues raised by the audit report rather than being made on a paragraph by paragraph basis. In addition to these comments, we would appreciate the opportunity to review the 19 California cases that the report identified as "abusers." If you could make this information available to us, we would submit our comments on this material for your use as well.

If you have questions on our response or wish to discuss any of this material further, please contact Rod Palmieri of my staff at (916) 323-6077.

Sincerely,

Eugene K. Lynch

Eugene K. Lynch
Deputy Director

COMMENTS BY THE STATE OF CALIFORNIA
ON THE REPORT TITLED
"MEDICAID: IMPROVEMENTS NEEDED IN PROGRAMS TO PREVENT ABUSE"
(Code 101099)
PREPARED BY THE U S GENERAL ACCOUNTING OFFICE

GENERAL COMMENTS ON ISSUES RAISED BY THE REPORT:

Now on p. 2.

1. Definition of abuse: Several times in the report, loose definitions of the term "abuse" are offered which are, at best, misleading. For example, on page 1 we found "Abuse occurs when a provider prescribes services that are not needed or are too expensive or when a Medicaid recipient obtains the same services from two or more providers, uses too many prescription drugs, or visits the doctor's office or emergency room too often." On page 10, we have "Providers can abuse Medicaid by providing unnecessary services, providing inordinate numbers of high cost services, or "ping ponging" recipients--unnecessarily referring recipients among a group of providers. Recipients can abuse Medicaid by obtaining duplicative services, using too many prescription drugs, using the emergency room for non-emergency services, visiting providers too often, or using multiple providers unnecessarily (doctor shopping)." These are definitions by example and are simultaneously too specific and not sufficiently explicit. We offer the following for your consideration: Provider abuse - providing services or causing services to be provided (through prescription, ordering or referral) in excess of medical necessity or of a type that is more expensive than necessary for the condition being treated. Recipient abuse (this definition is in a proposed California regulation) - Obtaining drugs or other services at a frequency or in an amount not medically necessary.

2. Although this report speaks in general terms of both provider and recipient abuse and the states' ability to control or sanction them, no specific data is presented in the provider area. We are interested in your observations of our provider identification and control system as well as what your findings were in the other states reviewed. If you include this material in your final report, we would appreciate the opportunity to first review a draft. If you choose not to include this material, we would appreciate it if you could provide your comments on our program separately.

3. Different sanctions to control provider or recipient abuse are mentioned throughout the report. It should be recognized that some states may not have all of the sanctions mentioned due to state regulation. (For example, California was the only state included in this report which uses prior authorization. We have used this process effectively for many years and believe it is superior to lock-in in many cases.) If a federal government agency wishes to take action against a provider or recipient based upon violation of a federal law or regulation, then the federal government can set the appropriate sanction. Since, however, most sanctions are imposed by state governments, only state laws and regulations governing such sanctions are applicable.

4. While fiscal savings is a primary goal of the postpayment utilization review program, the health status of recipients must also be considered. This was one of the reasons that our initial efforts were in the area of abusable drugs. Also, we do not believe it is advisable to send letters to recipients without first reviewing their records to determine if this use is justified. We know from our experience with BEOMBS and other beneficiary notices that the most carefully written documents are often misunderstood. If someone's utilization is high due to prolonged or severe illness, we would not want to exacerbate that condition by threatening sanctions due to this high utilization. It is this concern that leads to our strong belief that any definition of abuse must include the consideration of medical necessity.

5. There are many places in the report where the Beneficiary Utilization Review Unit in the California system is criticized for problems which are either nonexistent or had been corrected well before the audit. For example:

Now on p. 31.

a. The "class grouping" problem mentioned on page 38 was not a class grouping problem at all, but a system limitation that had previously gone unrecognized. Once we realized the nature of the problem, we restructured our class groups to avoid it.

b. The report describes historical background as the current system. Most of the references to system screens are to those in place in 1984 or earlier. Since late 1984, California has instituted many changes in the recipient screening system. These changes were described to the auditor who did not give recognition to them in the report. These changes include eliminating from the screening process those recipients least likely to abuse the program (people over 65, people in long term care, etc.) and those with severe conditions which may legitimately require a high level of care (diagnoses of cancer, chronic renal failure, congestive heart failure, etc.). Establishing screens for those drug prescriptions which have a hign abuse potential (valium, ritalin, percodan, dextroamphetamines, etc) instead of all drug prescriptions; for number of office, outpatient or emergency room visits for which the diagnosis was a "common" one (lumbago, neuritis, neuralgia, cold symptoms, dizziness, etc.) instead of all provider or emergency room visits; identifying the number of providers of office, outpatient or emergency room visits rather than just the most different providers.

c. The California screens are used in combination, rather than singly. That is, we believe obtaining a high level of abusable drugs from one or two prescribers may not be nearly as abusive as obtaining a like number from numerous prescribers. We also use emergency room measurements in conjunction with physician and outpatient visits in identifying patterns of abuse. We believe the use of these combinations in our automated system does a much better job of identifying abuse and minimizes manual intervention.

Now on p. 33.

6. The GAO criticizes HCFA for not giving stronger guidance to California based on the limited number of screens we use. In fact, we are currently using 12 report items for automated screening and using an additional 40 measurement items to help us in our manual review of the exceptional cases. Yet the GAO report considers the program operated by Texas to be an outstanding one in spite of the fact that Texas uses only two screens to determine potential abuse - the number of office visits and the number of emergency room visits (report pages 40 and 41).

7. At the time of this report, we were saving $5 million per year through the review of approximately 40,000 exceptional recipients at a cost of about $0.5 million, for a cost-to-benefit ratio of 10-to-1. According to Appendix I, the audit team subjected a sample of California's recipients to a series of federal screens which (if we accept the methods and assumptions) would lead to a savings of $4 million per year through the review of approximately 87,000 exceptional recipients at an estimated cost of at least $1 million. The cost-to-benefit ratio using these screens would be 4-to-1. The author of the report treats this $4 million per year cost avoidance as though it would be in addition to the savings already being achieved by California. Yet, in the text of the appendix there is no indication that this set of data is any different from that used by California in conducting our screens. Thus, we must conclude that the California screens are achieving a greater cost avoidance at a lower administrative cost than the screens recommended by GAO in this report could be expected to achieve.

COMMENTS ON GAO'S RECOMMENDATIONS:

1. Most of the recommendations hinge upon the first one - that is, that HCFA require the states to assess the extent of abuse using HCFA-developed criteria. California objects very strongly to this recommendation. Each state program is unique in its combination of program benefits, prepayment controls and payment structures. One set of postpayment abuse criteria cannot fit every state's needs, nor can it be used to compare states' performance.

2. This recommendation, which hinges on the first one, suggests the state must establish procedures, organizational structures and staffing levels based upon the "national criteria for abuse." California does not agree with this recommendation.

3. This recommendation obviously makes sense only if the first two are adopted. Even so, we question how the SPR would determine the "reasonableness" of such things as screens, class groups and parameters.

4/5/6. The SPR is not an appropriate vehicle to use to gather information and documentation on system problems or achievements. California would welcome, however, any vehicle for sharing these problems or innovative ideas. Also, California would prefer to ask for technical assistance when we feel the need rather than being told when we need it.

Comments From the State of Ohio

Richard F. Celeste
Governor

Ohio Department of Human Services

30 East Broad Street, Columbus, Ohio 43266-0423

June 9, 1987

Mr. Richard L. Fogel
Assistant Comptroller General
Human Resources Division
United States Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

Governor Celeste has forwarded to me for review and comment your proposed report to the Secretary of Health and Human Services entitled: "MEDICAID: Improvements Needed in Programs to Prevent Abuse". Ohio appreciates this opportunity and we are pleased to note that we have already installed many of the improvements that you are recommending. In addition, we have noted some approaches being used in other states that we plan to explore.

We agree with many of your points regarding the need for more sharing of information and technical assistance from HCFA, but the record should show that limited resources at all levels of government can affect what is possible. HCFA, Region 5 has been helpful in assisting us with our Surveillance and Utilization Review (SUR) system and has been supportive of our efforts to make our SUR system more efficient and effective.

Now on p. 43

Of special concern to us are your first two recommendations on page 56. Our concern is over what methodology would be used to identify the extent of abuse and the standards that might result for a state's review activity. The benefit of review activities must be evaluated against the cost. Each state's program is geared to the size of the Medicaid population, the number of providers, the standard of medical practice, and state laws, rules, and regulations. It is unrealistic to expect that what works in Wyoming necessarily will work in Ohio. We would urge that a range of acceptable performance trade offs between program methodology be evaluated. There is a danger in establishing a single standard for the nation as it may limit a state's ability to test an innovative monitoring approach.

OHIO
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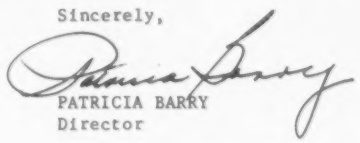
Mr. Richard L. Fogel
Page 2
June 9, 1987

Our specific comments on other sections of the report are attached for your information. Please be assured that Ohio is committed to a strong identification and sanction program for providers and recipients so as to prevent abuse at all levels. We will continue to work with the Health Care Financing Administration (HCFA), Region 5 to strengthen this effort in the Ohio Medicaid Program.

Sincerely,



PATRICIA BARRY
Director

PB:kc
Enclosures

OHIO DEPARTMENT OF HUMAN SERVICES

REVIEW AND COMMENT ON "MEDICAID: IMPROVEMENTS NEEDED IN PROGRAMS TO PREVENT ABUSE"

Unless otherwise indicated, comments are directed to the recipient monitoring system, which was the only program reviewed in Ohio.

Page: 4, Paragraph 3. Any paramaters that are established for states based on the extent of potential abuse, must be examined in terms of a cost benefit ratio. We should not spend more trying to eliminate potential abuse when it is not cost effective.

Now on p. 4.

Page: 5, Paragraph 3. In regard to Provider abuse, Ohio has recently started using education/warning letters to alert providers that their billing profiles are exceeding the norm for their peer grouping. This is similar to the Massachusetts program discussed on page 59. It is too early to determine the savings impact of these letters, but we anticipate having some estimates on this in the next twelve months.

Now on p. 55.

Now on p. 17.

Page: 19, Table 2.1. Ohio's lock-in program (PACT) has been expanded to 1,050 as of June 1, 1987. To enroll this number, approximately 4,400 recipients are reviewed each year. Proposed expansion plans call for us to enroll up to 8,000 recipients in the program by Fiscal Year 1989.

Now on p. 19.

Page: 22, Paragraph 3. Ohio agrees with the Texas assumption of targeting their notification letters.

Now on p. 21.

Page: 24, Paragraph 3. Ohio refers some recipient abuse cases to local welfare offices and to county prosecutors.

Now on p. 22.

Page: 25, Footnote a. Now that the new MMIS is operational, we are exploring the possibility of tracking savings by recipient. This will be determined during Fiscal Year 1988.

Now on p. 34.

Page: 32, Paragraph 3. HCFA, Region 5 has assisted us in orientation of a new bureau chief and provided us with the names of people in other states who were developing new approaches to SUR. We agree that we would like more technical assistance and the opportunity to have some workshops. Suggested topics would be setting paramaters, statistical sampling, and effective ways of dealing with quality issues with providers.

Now on p. 29.

Page: 36, Paragraph 2. The problem of assigning providers to appropriate class groups is more difficult than assigning recipients. We have found that updating a providers class group is a continuing job, and it is unrealistic to expect that these groupings will ever be perfect. It should be the norm that this is an evolutionary effort

Now on p. 33.

Page: 40, Paragraph 2. Ohio has experienced the same result as Texas in running the recipient portion of the SURS II system. We have proposed to substitute our PACT system (Lock-in) that runs off the MMIS. HCFA has been very cooperative in reviewing our request. We have every reason to believe that our request will be approved.

Now on p. 34.

Page: 42, Paragraph 3. Ohio has completed installation of its updated SURS system and has since installed a new MMIS. Problems have developed in merging the two systems. We are not able to fully utilize the SURS II system until these computer problems are resolved.

Now on p. 56.

Page: 60, Paragraph 4. This type of arbitrary practice standard is not compatible with our state program. It seems to us unfair to arbitrarily cut back reimbursement without examining the evidence of need. We do, however, make across the board adjustments on certain billing codes that are found to be not authorized or being misbilled. In addition, we are in the process of exploring a desk audit procedure to be used with providers whose annual billings do not warrant a full audit but whose patterns of practice appear to be exceptionally abusive.

Comments From the State of Louisiana

EDWIN W. EDWARDS
GOVERNOR

State of Louisiana
EXECUTIVE DEPARTMENT
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June 18, 1987

Richard A. Fogel
Assistant Comptroller General
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

This is in response to your letter of May 6, 1987, and your attached draft report, "MEDICAID: Improvements In Programs to Prevent Abuse".

Louisiana was pleased to participate in your staff's review of our Program Integrity activities regarding recipient abuse or misutilization of Medicaid services. We find, that, from our standpoint, the findings of this report are basically fair. However, there are some areas we would like to address.

1. HCFA's use of System Performance Review (SPR) to measure the effectiveness of SUR/S.

   Louisiana has been hoping for the development of a more appropriate mechanism to measure the effectiveness of the Surveillance Utilization Review Subsystem (SURS) and we have concerns about the current SPR which focuses primarily on the investigative nature of the case review process. Perhaps the State Technical Advisory Group could look further into developing a review process which considers SUR/S performance in greater detail than is now done.

2. Lack of Technical Assistance from HCFA.

Now on p. 34.

   On page 42 of your report you quote a Dallas Regional Office Official as saying that 4 out of 5 states in the region did not have staff that were really knowledgeable on SUR/S. He further said they (the states) lack the necessary system, statistical, administrative, and medical skills to use SUR/S data effectively. Without being facetious, the same is true of the Regional Office. They were unable to grant our request for technical assistance from Dallas or central office. The training and technical assistance secured by Louisiana came from a private consulting firm who specializes in SUR/S II design and implementation. This help has greatly improved our proficiency in SUR/S and we are cognizant of the fact that ongoing technical assistance would be of enormous help to us in fine tuning our SUR/S.

Richard A. Fogel
Page 2
June 18, 1987

3. Basic Philosophy of Recipient Misutilization

Louisiana has service limits on many Medicaid services. Because of these front end controls, there is more concentration by the SUR/S Unit on services which have no front end control and must be monitored by a post payment review. Our lock-in program espouses an educational philosophy that it is necessary to protect the recipient from over-utilizing drugs by lock-in or by a network of a provider communication initiated by four regional Peer Utilization Review Committees under contract to our fiscal intermediary. Much of their intervention results in a change of drug utilization without locking the recipient in. We are in the process of identifying a dollar savings on this type of intervention and on lock-in.

4. Availability of staff directly impacts successfulness of program activity.

Declining state revenues have resulted in reduction to services as well as staff. Loss of staff, especially in SUR/S, has resulted in Louisiana contracting with the fiscal intermediary to perform SUR/S functions. This resulted in a cost savings to the state due to the enhanced match rate of 75-25 rather than 50-50 when performed in-house. The contract and cost savings is based on minimum numbers of SPR cases plus complaint cases. Any increase in the number of cases could negatively impact us by increasing the cost for the contract.

5. The standard of a minimum number of SUR/S Cases per quarter

GAO Staff seem to be making the point that many states use these minimums as a means of limiting the number of cases to be reviewed each quarter. Again as stated above even the SPR bench mark is sometimes difficult to meet if there is insufficient manpower available to manage SUR/S. Fine tuning of the parameters of the control file can cause the most aberrant cases to "except" and some state criteria is necessary in order to choose from among the exceptions those cases which can be investigated within manpower limitations. We recommend we continue to have state control over the cases selected for review.

Thank you for allowing us to share these comments with you.

Kindest regards.

Sincerely,

EDWIN W. EDWARDS

EWE:pas

Comments From the State of Wisconsin

TOMMY G. THOMPSON

Governor
State of Wisconsin

June 16, 1987

Richard L. Fogel
Assistant Comptroller General
General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

Thank you for sharing your draft of the Surveillance and Utilization Review Study entitled "Medicaid: Improvements Needed in Programs to Prevent Abuse." Since Wisconsin was one of the states included in the review, I was particularly interested in your findings. I asked the Department of Health and Social Services to look at this report. The following are suggestions from the Department:

The Department agrees with your findings that the current federally required SUR system is not being effectively used. However, they believe it is not the review criteria used in the Systems Performance Review (SPR), but the entire approach that is the problem.

The Department recommends that states be given the option of setting up an alternative review system which uses a more targeted approach rather than the random sample/exception type of system currently required. They believe this methodology would allow us to better direct our limited resources to the areas that would be most cost/beneficial.

The alternative system mentioned above would target based on a more exacting peer grouping which not only use provider characteristics to group, but also recipient and disease characteristics. These groups would be defined using 24-month of paid claims data which is subjected to a factor analysis for arraying the chosen characteristics. These "profiles" would then be reviewed by medical personnel to insure that the data was reasonable and to interpret any outliers.

From these profiles, the state could construct a "logic tree" which would use the extracted claims that met the profile criteria and further refine the final extracted data showing those actual claims that were characteristic of abuse or fraud. This more targeted and automated approach would save manual effort on the part of audit staff and allow the state to focus in on areas of large dollar expeditures and questionable medical practices.

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The Health Care Financing Administration (HCFA) has allowed the states this option in the System Performance Review (SPR) for the Claims Processing Analysis System (CPAS) and Wisconsin has found its own alternative system to detect errors which could not be directed under the mandatory random sample methodology. A similar targeted approach in SUR would probably yield far better results than the currently required system.

I hope the Department's suggestions are helpful to you, and again, thanks for sharing the draft report with me.

Sincerely,

Tommy G. Thompson

TOMMY G. THOMPSON
Governor

TGT/csh

Comments From the State of Minnesota

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

June 4, 1987

Richard L. Fogel
Assistant Comptroller General
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

I have been asked by Governor Perpich to respond to your agency's request for comments regarding the draft of the proposed report: MEDICAID: Improvements Needed in Programs to Prevent Abuse (Code 101099).

As a general response, the report focuses too narrowly on the scope of Surveillance and Utilization Review (SUR) activity. The SUR subsystem of the MMIS is but one resource used in Minnesota's commitment to the identification, vigorous action against and prevention of abuse in the Medicaid program. The report leaves the impression that, in the main, the remedy for controlling abusive practice is to increase the federal standards and oversight for exception reporting. The "more is better" philosophy does not fit the SUR function.

Exception reports generated from the SUR subsystem indicate, rather than establish, abusive practices on the part of providers and recipients. These reports give states a systematic method of reviewing program participants' behavior compared to certain cohorts. Its value is relative, not absolute. Minnesota is opposed to the recommendation to use the SUR subsystem to establish estimates of potential abuse and tying minimum exception report review standards to these estimates. As pointed out in the report, state Medicaid programs differ significantly on service limitations requiring modifications to criteria identifying potential abuse. We would point out that additional modifications would be necessary due to variations of demography, service delivery systems and payment mechanisms between the states. The task of tailoring an individual potential abuse indicator for each state would be monumental, exacerbated by the admitted lack of federal resources.

The report places an unwarranted importance on the SUR exception reporting subsystem as the source of abuse identification. It is an important and useful tool that contributes to the mosaic of information sources used to conduct SUR activities. Any good quality control system relies upon a variety of sources to detect and correct aberrations. The recommendations in the report would divert total staff resources to one monitoring device, the SUR subsystem, at the expense of other productive avenues of abuse detection.

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The report places a great deal of emphasis on the lack of technical and program assistance provided by the federal agency. We believe that building such a capacity in HCFA would not be productive. The technical expertise in the SUR subsystem rests with the vendors that have developed and support the system. HCFA could do more to make these resources available to states through enhanced funding of routine, on-site vendor consultations.

On the other hand, program expertise regarding innovative SUR techniques rests in the various state SUR units. The National Association of SURS Officials (NASO) is an organization that grew out of the need to share information on SUR activities. NASO has just completed its third year of existence. Its annual conference is attended by over one-hundred members, representing at least thirty-five states. The organization publishes a quarterly newsletter containing the type of information the GAO report identified as useful. Additionally, SUR staff have available to them, names, addresses and phone numbers of their counterparts in other states for informal phone consultation.

Now on pp. 3 and 30.

There are a few specific items in your report that I would like to comment on. On pages three and thirty-seven, it is noted that Minnesota was focusing on the elderly and institutionalized recipients. The Systems Performance Review (SPR) requires states to process all class groups at least annually. Some groups are run two or three times in a year. The review period covered by the report happened to contain a back-to-back run for elderly and institutionalized persons. Only sixteen potential abusers were identified in one of those groups because exception criteria had been changed. Errors of this sort will occasionally occur when these reports are being used and modified as required. Although restriction rarely results from reviews in these kinds of class groups, it is not uncommon for referrals to be sent to our Drug Utilization Review Program, where educational letters are sent to physicians and pharmacies regarding the drug regimen.

Now on p. 37.

On page forty-seven, you list the SPR requirements and number of "abusers reviewed" for Minnesota and three other states. The Minnesota review requirement you show is thirty-six, and the number of reviews range from thirty to seventy-five. Please note that this state did pass SPR Factor GK1 in 1985, as well as in other years. The class group figures that total up to 360,000 recipients are duplicative, some recipients are counted in more than one class group. Factoring out this duplication results in a total number of active recipients as being closer to 258,000. Thus twenty-six, or .01% of the number of active recipients would be the minimum requirement.

Finally, the report suggests that the recipient review program in Minnesota exerts the minimum effort to maintain federal financial participation. This agency is very concerned about recipients who abuse the program both from the standpoint of potential physical harm and lost tax dollars. We will continue

to do more than what is minimally required to safeguard recipient health and program integrity. To do this, we must respond to all information resources and not rely solely on exception reports.

I appreciate the opportunity to comment on the draft report and trust that any change in the Systems Performance Review result in increased capacity of states to deal with abuse rather than requiring increased activity without results.

Sincerely,

for SANDRA S. GARDEBRING
Commissioner

Comments From the Commonwealth of Massachusetts

CHARLES M. ATKINS
Commissioner

The Commonwealth of Massachusetts
Executive Office of Human Services
Department of Public Welfare
600 Washington Street, Boston 02111

August 3, 1987

Richard L. Fogel
Assistant Comptroller General
U.S. General Accounting Office
441 G Street, GAO Building
Washington D.C. 02548

RE: Comments on GAO Draft Report
Log #113-330

Dear Mr. Fogel:

The Commissioner has asked me to respond to your letter requesting comments on the General Accounting Office (GAO) draft report entitled, "MEDICAID: Improvements Needed In Programs to Prevent Abuse (Code 101099)".

I am pleased to report that the Department has already taken steps to address many of the recommendations cited in your draft report regarding provider and recipient abuse prevention. Massachusetts has established an aggressive cost savings agenda, producing $217 million in Medicaid savings during FY86 and a projected $296 million in FY87. These savings compare favorably with other states having similar demographics and economies. Additionally, the Department's Medicaid error rates have been significantly lower than those required by federal standards. The success of the savings agenda and the lowered error rates have been primarily attributable to the expanded use of the Medicaid Management Information System (MMIS) for claims editing capabilities, recoveries from targeted retrospective provider audits and increased billing of third party health insurers for services rendered to Medicaid recipients.

MMIS currently has some 600 edits in place to insure appropriate payments are made. Among the many edits used to control payments and prevent abuse are edits for duplicate billings, nonreimbursable and overlapping services and incompatible (mutually exclusive) services. Additionally, MMIS reporting subsystem data is utilized to identify potential aberrant provider practice patterns for provider education and auditing purposes. Other significant aspects of the Department's expenditure control and benefit management operations include: an aggressive Compliance and Financial Review Unit agenda for auditing and reviewing Medicaid providers, a strongly supportive and close working relationship with the Medicaid Fraud Control Unit of the Massachusetts Attorney General's office and the new Health Systems Management Unit implemented during FY 1987.

The Health Systems Management unit will help prevent further provider abuse through strategies including restructuring previous approaches to managing Medicaid programs and expenditures and emphasizing control of fundamental factors exerting upward pressure on Medicaid costs. Staff members of this unit are specialists by a provider type, (i.e. acute hospital, skilled nursing facility, physician, etc.) and work closely with Medical Assistance Program staff to improve program management through their specialized knowledge of provider types, their broad overview of Medicaid and the health care industry and their use of management information available from MMIS.

Massachusetts has implemented a number of the "abuse control" techniques identified in chapter four of the draft report. Listed below are summaries of the Commonwealth's use of the identified techniques:

- The Department has identified overpayments without onsite audits for several years, relying on the MMIS system to calculate overpayments for numerous projects and terminations.

- Sanctions and terminations of Medicaid providers have been based on peer review recommendations for a number of years.

- As your draft report indicates, the Department has initiated provider education letters in certain specific situations. An expanded provider education program including both provider education letters and peer visits to discuss problem areas with providers having aberrant service delivery or billing patterns is planned for FY88.

Throughout this administration, the Department has worked closely with the Health Care Financing Administration (HCFA) regional and central office staff. The success we have attained in our Medical Assistance Program, particularly in improving the efficiency of MMIS, is directly attributable to the technical assistance and programmatic advice provided by the HCFA Region I Office.

As is evidenced by the Commonwealth's aggressive cost savings agenda and low error rate, Massachusetts strives to be a leader in identifying and preventing provider and recipient abuse through the maximization of the Medicaid Management Information System and other management tools. Massachusetts supports the draft report's recommendations in chapter three that closer state/federal partnerships are conducive to provision of the most efficient and effective MMIS operation. However, we do not support the finding that the existing Systems Performance Review (SPR) process may be inadequate and would not support modifications to the current approach without further documentation of SPR ineffectiveness.

We appreciate having had the opportunity to comment on the draft report. If you have any questions, please feel free to contact either Carmen Canino, Associate Commissioner for Medicaid, or Thomas P. Sellers, Assistant Commissioner for Finance.

Sincerely,

Robert D. Wakefield, Jr., Director
Compliance and Financial Review Unit
Medical Assistance Program

RDW:TT:ms (TT23)
cc: Jim Linz, General Accounting Office

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